

**A Phenomenological Study of the Lived Experience of Culturally Sensitive Care in a  
First Nation Community**

**By**

**Donna Leanne Kelly  
BSN, University of Saskatchewan, 1989**

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Supervisor: Dr. Anita Molzahn

### ABSTRACT

The term, *culturally sensitive care* has been used extensively in health care literature but has not been satisfactorily defined or operationalized. In this phenomenological study, effort is made to examine the lived experience and perceptions of four Aboriginal women who access services at a community health center designed for and managed by Aboriginal people. The study looks at data collected through intensive interviews with each of the women and findings are generated through identification of five main themes that are relevant to all four women. These include: identity as an Aboriginal woman, experiences of racism, perceptions of culture, societal systems and relationships at Tsewultun Health Center. The overall premise of this study is that of Aboriginal culture being in an ongoing state of evolution and transition given the forces that shape our society. Adapting services and ways of caring to include an awareness and understanding of these issues is imperative.

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## DEDICATION

*I would like to dedicate this effort simply to all the people who have entered my life in some way or another so as to inspire in me a notion to find truth and peace. This, I especially address to my mother, who's fear and shame of her ancestry has driven me closer to mine, to my husband who's steady frame and protective nature has given me strength to go forward, and to my two sons, to whom I will pass on my questions and hope that they will continue to search their own hearts for answers.*

## **CHAPTER 1**

### **INTRODUCTION**

#### **Purpose Statement**

The purpose of this phenomenological study is to describe the lived experience of Aboriginal women who have accessed what is considered to be culturally sensitive health care from an agency that is situated to provide such a service. The trend towards providing culturally sensitive care is picking up momentum in our multicultural society. What that term actually means is not clear to me, especially in the context of Aboriginal culture. Many factors influence who an individual becomes throughout her life. For aboriginal women, the impact of history, European contact, and oppression plays an immeasurable part. Providing culturally sensitive care, then, must take into account all these factors if one is truly going to meet the needs of this specific population. The problem lies in the fact that much of the research done on Aboriginal groups relies on the traditional stereotypes of North American Indian groups as studied by anthropologists in the past. The perspectives of today's Aboriginal peoples are only rarely considered. My study hopes to address this problem. Just what is relevant for Aboriginal women seeking health care and what is their experience of that?

#### **Background to the Study**

##### Circle the Wagons

*There it is again, the circle, that goddamned circle, as if we thought in circles, judged things on the merit of their circularity, as if all we ate was bologna and bannock, drank Tetley tea, so many times 'we are' the circle, the medicine wheel, the moon, the womb, and sacred hoops, you'd think we were one big tribe, is there nothing more than the circle in the deep structure of native literature? Are my eyes circles yet? Yet I feel*



*compelled to incorporate something circular into the text, plot, or narrative structure because if it's linear then that proves that I'm a ghost and that native culture really has vanished and what is all this fuss about appropriation anyway? Are my eyes round yet? There are times when I feel that if I don't have a circle or the number four or legend in my poetry, I am lost, just a fading urban Indian caught in all the trappings of Doc Martens, cappuccinos and foreign films but there it is again orbiting, lunar, hoops encompassing your thoughts and canonizing mine, there it is again, circle the wagons....*  
(Dumont, 1995)

This piece of writing is from a book of poetry written by a Metis woman named Marilyn Dumont. When I first read this piece I was thunderstruck. Yes! I thought. I understand her ideas. I have struggled with my own identity as a Metis woman. I know that at times I have felt like a lost soul when I compared myself to the character traits identified as being Indian in some piece of academic or journalistic writing. How much of an Indian am I? How much are any of us? On the continuum of skin tone, is there not a corresponding assimilation scale as well?

When I read the words of writers such as Ms. Dumont, expressing the sentiments of Aboriginal women across this country I respond at an emotional level. I long to hear truths from their lips telling me what it is truly like for them, living in this country as we turn to a new millenium. What is the reality of trying to fit into a "traditional" stereotype forged at the hands of well intentioned scholars and historians?

For me, to feel is to learn. To feel is to know. My questions come from an emotional place. The words of the literary artists such as Dumont, describing the lives of Aboriginal women in North America, help me to complete the picture. These words complete the circle of knowledge that the statisticians and researchers have attempted to examine. It is not enough to simply complete a "study" on this group of people. It is not

enough to slide into a community, ask questions, observe, reflect and then slip out as grotesquely objective as upon entering. It is not enough to publish all that is written down in the field notes without trying to level the field. These subjects are people. N = Mary, Joanne, and Lois. The methodology leaves its mark on their faces and the analysis is more than just a publishable article, it is a history of living.

### **Personal Journey / My Situatedness**

My experience as an Aboriginal woman working as a nurse in Aboriginal communities has left me with some questions regarding the research done on and in Aboriginal communities. There is an eagerness for the nursing profession to learn about Aboriginal peoples, but there is a reluctance for me to share what I know. It has something to do with my own issues of identity and something to do with trust. How much can I share and be sure that it will not be exploited? What can I say that will make these nurses feel what I feel? How can I convey what is to be an Aboriginal woman in Canada? How will the exchange of knowledge influence the kind of care that is given and received? I believe that my task is to carry out my research in a way that will be true to the realities of "Indianness" in today's world, and to the emotional lives of the women whom I interview. I must try to make others feel what I feel.

I must articulate my own journey in this research process as it has changed the very nature of my perspectives on my nursing practice and my feelings about myself as an Aboriginal woman. I began the Masters program not having a clear idea of what my thesis project would be, but I did know that I wanted to do something related to

Aboriginal women. When I began the Masters program I had not yet had any children. Over the next few years I worked through my required courses part time while having two beautiful baby boys. No one ever tells you how much having children will change your life, but of course my boys changed mine. It became important for me to know who I was and to be comfortable with that for my sons. I needed to be okay with answering questions about something as simple as choosing their names to thinking through the painful experiences of my past that they may ask about someday.

I recall being in one of my classes where the dynamics among the students had taken a turn towards being tense. For many reasons it was suggested that we hold a healing/talking circle. As I sat listening to the other students speak, I began to wonder what I could share that would fit with the group. My turn came and I began speaking about how I felt being one of the few Aboriginal women in the course and of feeling the pressure to "explain" things from an Aboriginal perspective. I began babbling about being native and before I realized it I was relating a story about a friend of mine who had a child with a white man and whose daughter was now in school. The daughter was very fair skinned and very embarrassed about her mom and refused to allow her to attend her school functions. I started to cry and I expressed my own fear of this same thing happening to me. How could I bear to have my own sons be embarrassed about me? I did not realize until that time how afraid I was of this situation. When I got home that evening I talked at great length about the issue with my non-native partner. I began to think about what being native meant to me and how to go about defining myself. I imagined myself trying to explain my ancestry to my sons in terms that they could

understand. References to "cowboys and Indians" kept coming up. I realized that I did not truly know myself what it meant to me to be native in this world at this time.

One of the elective courses that I took was about native women's autobiographies. Our major assignment was an autobiography of ourselves. I couldn't imagine a more daunting task. The whole idea of writing about me and my life was foreign to me. The instructor did not simply want a chronology, but an indepth look at some aspect of our life that was important to us. I finally settled on my struggle with my identity and all the issues involved in that.

For me, this assignment was the pivotal point in my masters program. I now knew what I wanted to study for my thesis. If my struggle with my identity was so real for me and influenced how and what I did in my life, could it not be so for other women? Or were things so clear for women raised with definite cultural boundaries that there was no struggle? Where on the continuum of native-ness did women see themselves and did that influence their decisions for living?

Since I worked at a health center that professed to provide care for the women of the community in a way that met their cultural needs I was curious about how real this was for women. Was it an identifiable factor in their decision making, or did it just fit into the subconscious context of their daily life?

From a personal standpoint, I need to identify that I am motivated by my own quest for answers. I have a pre-existing perspective of seeing culture as existing on a continuum, influenced by the dominant society and shaped by our personal experiences with life. The idea that "an Indian is an Indian is an Indian" is just not true. Just what we

are I am not sure either, but for a start, I would like to know how we work with this concept in our nursing practice and how it plays out for individual Aboriginal women.

### **Issues and Assumptions Embedded in the Study**

#### *Race*

The issue of race is inherently linked to any study where ethnicity and/or culture are key factors. Why must we acknowledge that there are differences? Can't we just all be the same? This question in itself speaks volumes. The same. What same? How are we to decide the standard of sameness? Should we all become the same as the ideal white Anglo protestant male? Or should we follow the behavior rules of some other culture? Inevitably when this question is asked, it is being asked by someone tied to the dominant culture, who sees things through an Euro-centric lens. It is an inconvenience for people to adapt to others. It is an annoyance to tolerate differences, especially if they cut into the establishment. The dominant culture makes the rules and these rules are very difficult to adapt to new situations.

In Canada we have a history of attempted assimilation of Aboriginal peoples into the dominant European culture. That has formed the basis for attitudes and relationships between "them and us". Aboriginal people in this country have been oppressed. The legacy of that oppression is obvious in the socioeconomic, health, and education status of native peoples across this country. So it is inevitable that race becomes a factor in interactions between a health care practitioner and a client.

At Tsewutun Health Center, when I began, I used to hear lots of complaints "just

between you and me" about "those white nurses". It was important for some of the women that I met that I was Native and they often would not remember my name but would ask at the front desk to see that "Native nurse." Even though I was not from the community, nor did I have any real knowledge about the Coast Salish culture, my physical appearance was important. I was Native and along with that went the assumptions that I knew what it was like to be a Native woman. In fact, I did know what it was like to be me as a Native woman. I know about the taunting and ridicule about dirty Indians. I knew that I was ashamed at times in my life to speak about my ancestry. I knew that generally being Native in Canada was equivalent to being on about the lowest rung on the ethnicity scale. I didn't specifically know what it was like to be a Coast Salish woman living on Vancouver Island. Nor did I know anything about the ceremonial culture that many women practiced. Nor about growing up on an urban reserve. No, there were many things I did not know. But I was still accepted as being "one of us".

There is a solidarity that exists among Aboriginal people in this country. If you identify with the tag at all, there is always some force that will acknowledge your Indianness in an inclusive way. By this I mean, my acceptance in the community. An example is the way eye contact is made when I see another Native person in a mall or on the street. Even if we do not know each other, there is always a look and a subtle nod or smile. It is a *knowing*. A respect for the perceived solidarity that we share. This, of course has only been made available to me since I have become comfortable with who I am. There was a time when I would cross a street just to avoid walking by someone that I identified as Native. If I could not avoid the close proximity, I would not in any way

look at them, or acknowledge them. This illustrates that it is just not race itself that influences the living culture but the perception of self and attachment to the values of that specific race or ethnicity.

I also believe that people are inherently racist. By this I mean that all people have an awareness of race on a very subconscious level. This is not necessarily a negative thing, but it is a reality that people see things through their own lens and that the lens of the dominant culture is invisible but very powerful. This does not mean that people can not be empathetic to others nor try to learn about the ways of other cultures. I just believe that until we are confronted with something that challenges our way of knowing, we do not even realize that we may be ethnocentric, and ultimately racist to some degree.

### *Transfer*

Transfer is the term that is being used to name the current initiatives by the federal government to transfer the control and administration of health care services from the federal government to First Nations' community control. There are many issues involved in this but one of relevance for my research is the premise that culturally sensitive care will be enhanced when transfer is complete. Tsewultun Health Center has been a transferred Band for ten years. The mission statement says that the health center *"promotes a strong healthy community, in the spirit of co-operation, from the wisdom of our Elder's we will put into practise traditional and non-traditional ways to achieve an emotional spiritual, mental and physical well being."* This statement implies that weight will be given to the traditional culture that exists in the community in a way that will

foster positive growth.

There is also a belief, real or perceived, within the transfer movement generally that Aboriginal nurses are the more appropriate people to provide health services to Aboriginal communities. This may be for several reasons: they provide positive role modelling, they have an inherent understanding of the situations that exist on reserves/communities, they are less threatening to the people of the communities and may break down barriers that inhibit access to health services, and they may be able to provide culturally sensitive care (Health Canada, 1991). All of these reasons seem valid, and completely logical. My question here is, what about the individual differences among Aboriginal nurses? Consider the assimilation continuum that was mentioned earlier, and depending on where one is situated on that, the culturally sensitive nursing care provided might look very different.

With this trend in First Nations health care, my concern is that there may be a misconception that along with an ethnicity comes a competence that is assumed. It is important for First Nations communities to control their own health care services, but I do not think that the mandate to hire Aboriginal nurses inherently guarantees successful implementation of care that is culturally sensitive. Despite this nagging question that I have about the culturally sensitive aspects of care, I do lean towards the belief that Native nurses are better suited to work in First Nations communities, if only for the purpose of breaking down barriers at the first contact. My experience showed me that even though members of the community did not know me, when they saw my face, they were immediately responsive to my interaction. Most of the people I meet for the first time



want to know where I am from and what family I may or may not be related to. This crucial first impression breaks the ice, but after that it is up to me and my skill as a practitioner to continue that relationship.

### *Culture*

The last issue that I want to mention as being embedded in this study is that of culture. There is no one satisfactory definition of the word. I have an abstract sense of what this concept means for me. What I need to express here are some of my thoughts about this issue.

I distinguish between what I call ceremonial culture and the culture of our daily living. When I think of ceremonial culture, I think of ritual, ceremony, traditions etc. For the Cowichan people ceremonial culture revolves around the winter season and the Long House tradition. Families are shifted, jobs are put aside, an economy of trade, service, and money appears. I don't feel competent to describe or even comment on the significance of this specific ceremonial culture. The longer I work at Tsewultun the more I learn about it, albeit on a very superficial level. My instincts are to respectfully decline from discussing or questioning the ways of the winter. My sense of the culture is that the Cowichan are very protective about their ways. For my nursing care, I need not know the ins and outs of the rituals, but I should know something of the impact on daily living that they may engender.

The culture of daily living is the culture that I concern myself with as a nurse. For me this encompasses how and where a person lives. Are they in town? On reserve? Do

they have physical access to service? Do they work? What is their income level? Single parent family? Number of children? Ability to interact with the dominant society? Support systems? Education level? Resources? Beliefs that affect their wellness patterns? Diet and food sources? Parenting methods and beliefs? Sense of self esteem and their place in the world. etc. I believe that the determinants of health are very relevant when providing care for any oppressed group and they mirror, if not define, much of the daily culture of living and surviving.

So how does all this information about my situatedness, my perception of culture and my assumptions fit together to form a research question? By first defining and sorting through what I believe, what I know and how I feel, I can then try to identify what others may feel and think through what they tell me in their interviews. The concept that I am attempting to investigate, through the eyes of community women, are embedded with all the issues I have identified. I want to know if these issues are also real for the women in the study and if this concept of "culturally sensitive care" has any meaning at all for community members. How is it played out in real life? To what degree do Aboriginal women perceive this concept as important? Are they more concerned about comfort and survival and getting what they need? In this study, my research question is: **What is the actual lived experience of aboriginal women who have received what is considered to be culturally sensitive care?**

## **CHAPTER 2**

### **THE CONTEXT OF ABORIGINAL WOMEN'S HEALTH**

In this chapter I will look at the context of Aboriginal women's health by exploring the current literature in five key topic areas: culture, Aboriginal culture specifically, health status, the health care system, and the meanings of cultural care.

Although this may seem like an abundance of subject matter to cover, I emphasize that I do not intend to explore each of these topics in depth, but to enlist each of these areas to set the current milieu and context within which Aboriginal women exist and have been studied to date.

## Culture

### **moving camp too far (nila northSun, 1986)**

i can't speak of  
     many moons  
     moving camp on travois  
 i can't tell of  
     the last great battle  
     counting coup or  
     taking scalps  
 i don't know what it  
     was to hunt buffalo  
     or do the ghost dance  
 but  
 i can see an eagle  
     almost extinct  
     on slurpee plastic cups  
 i can travel to powwows  
     in campers & winnebagos  
 i can eat buffalo meat  
     at the tourist burger stand  
 i can dance to indian music  
     rock-n-roll hey-a-hey-o  
 i can  
 & unfortunately  
 i do.

In Canada, we live in a multicultural society. The expression of those cultures within an individual can vary widely between racial groups and even within racial groups.

In the poem presented, the reality of the author's experience of her culture is described. It is not what stereotypes might lead one to believe. In the following discussion of the context of Aboriginal women's health, I will talk about this issue of culture and its influences. How culture actually manifests itself within people is imperative to consider

if we are hoping to be able to adapt our nursing practices to meet the needs of our clients. It is important that we recognize the impact of culture on the relationships in health care, but also the diversity among cultures and the societal influences that may change our expectations. The following discussion is a review of some of the concepts of culture and Aboriginal culture that I have found in the literature and through critical examination of myself.

Culture, in itself, is very difficult to define, and there are as many definitions in the scholarly journals as there are questions about it. Instead of one set definition, below I have included defining terms from several journal sources that I find applicable and thought provoking.

Culture is more than the sum of its parts ( Willms, et al., 1992) and should not be defined as simply a specific race, religion or color ( Habayeb, 1995). Madeline Leinenger says that culture refers to "the learned, shared, and transmitted values, beliefs, norms and lifeways of a particular group that guides their thinking, decisions, and actions in patterned ways" (1991, p. 47). Davis talks about the term "ethnic identity" as being the important criterion. She offers the definition used by Phinney (found in Davis, 1996 p. 21) as "an individual's sense of self as a member of an ethnic group and the attitudes and behaviours associated with that sense". She goes on to say that ethnic identity then is composed of values, beliefs, and culture and the importance of these elements to the population possessing them (Davis, 1996).

In my view, culture is not so much a definable term as it is a feeling. I tend to favour Davis's use of the words ethnic identity because it implies a choice. Although it

may not be a conscious choice, or one that is even possible, her definition allows diversity to exist even among genetically defined racial groups. I feel close to members of the Aboriginal population not only because there are similar values, beliefs and experiences in our backgrounds, but also because I have chosen to follow a path to connect with my roots. If I had chosen a path that followed the values of the dominant society and suddenly I was thrust into the role of "Indian" as defined by generalized and historical cultural characteristics of my genetic ancestry, I would be as lost as those who are thrust the other way. It is a sense of belonging. It is a sense of knowing inherently on the inside, who you are, or at the very least struggling to find that knowledge. It is a tacit understanding and it becomes apparent only when you are faced with beliefs, values or norms that are different from your own.

### **Aboriginal Culture**

As an Aboriginal woman, I am aware of my differences that exist in the face of the mainstream society. My reality is however, that I have grown up and been encouraged to assimilate with the mainstream in order to blend in and achieve. Just how this ideology has influenced my experience of being an Aboriginal woman is of great interest to me. What forces exist that influence that experience for others? What is "traditional culture", and how does our idea of this phenomenon influence our understanding of health care interactions?

Traditional systems of North American Aboriginal people have been studied at length. There is general agreement in the research that indicates that illness and disease

are perceived as a result of imbalance or disharmony within the individual and the world (both the physical and spiritual world) around them. Wellness is perceived as achieving a state of balance among the physical, emotional, intellectual and the spiritual aspects of self. When this balance is disrupted, illness results (Dempsey & Gesse, 1995; Goforth Parker, 1994; Huttlinger K., 1989; Huttlinger & Tanner, 1994; Klyde, 1994; Sanchez, Plawecki, & Plawecki, 1996; Strickland, 1996; Turton, 1997 ). This imbalance may be the result of physical, psychological, or societal stressors. Given the history of oppression of Aboriginal people in North America and their resulting marginalization it follows that there has been ample opportunity for these imbalances to occur. The report of the Royal Commission on Aboriginal peoples (1996) summarizes the native concept of health as:

holistic because it integrates and gives equal emphasis to the physical, spiritual, mental and emotional aspects of the person. The circle is used to represent the inseparability of the individual, family, community and world...The circle (or wheel) embodies the notion of health as harmony or balance in all aspects of one's life...[human beings] must be in balance with their physical and social environments...in order to live and grow. Imbalance can threaten the conditions that enable each person to reach his or her full potential as a human being (p.205).

Aboriginal women have a special role among the health and healing lore of traditional society. Women are perceived as the "carriers of nations..." (Absolon, Herbert, & MacDonald, 1996) among their own people and thus have an esteemed cultural position. Women's roles in the birth, care and nurturing of children and families remain solid amidst the powerlessness of poverty, and the stresses of modern society.

In the Royal Commission (1996) report, there is an excerpt of two women

speaking about the way they knew women's roles to be in the past, in a less tainted version of native society. One woman says: *"Woman has had a traditional role as Centre, maintaining the fire - the fire which is at the centre of our belief. She is the keeper of the culture. She has been able to play that role even in a home divided....."*

The other woman replies, *"....At the beginning, when the 'others' first came here, we held our rightful positions in our societies, and held the respect due us by the men, because that's the way things were then, when we were following our ways. At that time, the European woman was considered an appendage to her husband, his possession. Contact with that...and the imposition of his ways on our people, resulted in our being assimilated into those ways. We forgot our women's responsibilities and the men forgot theirs."*

(Royal Commission, 1996, p. 19)

The way the Aboriginal women of the past are described sounds almost idyllic. Regardless of whether or not the roles were actually as idyllic as they sound, there is a history among Aboriginal women of the losses they have suffered throughout the years of colonization. Many changes have occurred in the wake of European contact. Historically, women in traditional societies were never portrayed as mindless, simple or oppressed. The power of their femininity was not questioned or undermined. There was a distinct role for the skills and nature of being a woman. In European history, women are often portrayed as the weaker sex, and of little value other than to procreate. The Christian religions promote the Madonna image of women as one to be aspired to, incorporating silence and obedience to the male counterpart. These new European values were imposed and made to appear superior to traditional ones. The patriarchal nature of the



European society being transposed on Aboriginal women created a disparity of cultural definitions that has left confusion for the many generations of Aboriginal women who were once worthy and productive partners. Aboriginal women in today's society have experienced many losses and are struggling to find meaning in their existence and repair damage done to their self esteem.

The impact of residential school fundamentally changed the parenting role and stripped them of the familial ties that were responsible for imparting knowledge and tradition. Government disenfranchisement meant that many women were stripped of their Indian identity when they became involved with non-Indian men, only to be left to survive on their own when their men decided they had had enough of them. This often resulted in loss of land, family ties and the rights granted through the Treaty process. With the creation of Bill C-31, the government attempted to return Indian status to those women who had unfairly lost it in the past. This too, created trouble of its own when these women attempted to return to their communities. The competition for resources and the perpetuation of past hurts only added to the sense of alienation for many of these women.

Aboriginal women have endured enormous impacts and assaults on their personhood. The modern context of sexuality as dirty and menstruation as something to be ashamed about has influenced how women generally have been marginalized in society. Aboriginal women as a disenfranchised minority are even more vulnerable as a population. Women are now often seen struggling with systemic and familial abuse, poverty, substance abuse, single parenthood and the racist attitudes from the outside

world.

Among the many changes Aboriginal women have endured, the impact of urbanization merits a short discussion. To the uninformed public, Indians are a group of people who reside on reserves created by the federal government. This statement is no longer true, and the fact is that almost half of the Aboriginal people in Canada live in cities and towns (Royal Commission, 1996). Historically, Indians did indeed live in the rural areas of the country, on parcels of land defined for them by the government of Canada as a means to *keep Indians in their place*. But in the last fifty years the migration from the reserve to the city by young Aboriginal people has been steady. It is a common perception that Aboriginal culture is incompatible with the demands of industrialized urban society and that in order to succeed in the city Aboriginal people must abandon their cultural identity (Royal Commission, 1996). Findings of the Royal Commission contradict the idea that Aboriginal people consider their culture irrelevant in the city, and they emphasize that in order to cope with the urban milieu support for maintaining their identity is essential. Whenever that support is absent, the urban experience is profoundly unhappy for Aboriginal people (Royal Commission, 1996). It is interesting to note that Strickland et al. (1996) reported that "many Indian people believe that the basis of illness is a loss of one's sense of self and identity, and therefore prevention is directed toward strengthening the identity." (p. 147).

In the city, there are not usually the extended cultural networks of the home that one might have left behind. In addition, the values of the dominant society press heavily on the cultural boundaries of the minority individual potentially resulting in a cultural

collision leading to identity confusion (Royal Commission, 1996). Adaptations to this run the gamut from maintenance of a strong cultural identity to assimilation into the dominant culture and turning away from old belief systems. Some Aboriginal people remain trapped between the two worlds, unable to find a place that suits them while others are able to blend aspects of both cultures and become bicultural (Royal Commission, 1996).

The culture shock for some results from the stress of an unwelcoming city, confusion, experiences of racism and inability to find employment. The view of self that gets reflected back invariably impacts the sense of self worth and identity (Royal Commission, 1996). The institutions of the city are often incompatible with Aboriginal cultural values. The welfare system, for example, has substituted institutional dependency for reliance on extended family . Urban schools lack opportunity for learning native languages and do not include curricula that accurately portray Aboriginal history (Royal Commission, 1996).

Whatever the case, it is evident that the notion of Indians being encapsulated within a static culture exhibiting specific cultural characteristics is erroneous. What is more likely is the Indian person struggling to make sense of a world where traditional values, imbedded deep within them, are in conflict with the world around them. Socioeconomic status, societal pressures, lack of self worth, desire to be accepted and identity confusion all influence the traditional world view. Societal forces must be acknowledged as a major influence on the behaviours of all people and groups over the course of time. Hatton (1994) talks about contemporary health beliefs and practices

among older urban Indians. She says that these beliefs

reflect a lifetime of interactions within a context of particularly relevant factors.

First, as a consequence of *historical factors*, including adversity and the untimely deaths of significant others, these individuals often lost those who were the bearers of traditions and the teachers of traditional health beliefs and practices.

Second, *political factors* as exemplified by a wardship status and consequent educational and health experiences, create settings in which these individuals have repeatedly received biomedical treatments. Third, *geographical factors* have relevance for the increasing accessibility of biomedical and commercial health care options and the decreasing accessibility of traditional options. Fourth, *sociocultural factors*, including a lifetime of interactions with health care providers, friends and family in an urbanized, multicultural community, have consequences for how these older adults construct their ideas of health and manage their health problems. (p.401)

Dutton (1983) summarizes this whole idea of the impact of the larger society on a minority group by saying:

It should be remembered that any Indian group, or even an Indian family, is now in a transitional stage. They are torn between their own ancient standards and those that are being urged or thrust upon them by those of non-Indian culture. (p. 12)

This last statement very clearly states what I believe to be true. There is no pure traditional culture any longer. People exist in a milieu of many other people. Media and technology change the way we communicate and go about our daily lives. We must recognize this fact in any interaction with people where culture is an issue. Canada's Aboriginal women are no different. There are common cultural and historical issues but there are also modern influences that frame our survival.

### **Health Status**

Just what does survival look like for the majority of Canada's Aboriginal (includes registered status Indians, unregistered or non-status Indians , Métis and Inuit) women? This question can be partially answered by briefly looking at some of the current statistics. In Canada, the life expectancy for women in 1991 was 80.9 years, and for men, 74.6 as compared with the total Aboriginal rates of 75.0 and 67.9 respectively (Statistics Canada, 1995). In British Columbia, the Aboriginal population is younger and growing faster than the rest of the province's population. Many Aboriginal women are moving into their childbearing years while the rest of BC's population is aging (McBride et al., 1992; Aboriginal Health Policy Branch, 1994). The status Indian birth rate is four times the provincial rate (Absolon et al., 1996). With the high rates of alcohol and drug related problems in Aboriginal communities, the potential for fetal alcohol affected children, single parent families and other social problems is apparent.

The infant mortality rate for Aboriginal people is twice that of the rest of the population. (Aboriginal Health Policy Branch, 1994). Specific cancers such as cervical,

gallbladder and stomach cancers have elevated mortality rates, up to four to six times higher in Aboriginal women than non-aboriginal women (McBride, 1992). One out of every three Aboriginal women is abused by her partner as compared to one out of ten provincially and one out of eight in Canada (Aboriginal Health Policy Branch, 1994). Suicide rates among Aboriginal women are more than double the average for Canadian women (McBride et al., 1992). The incidence of disease such as tuberculosis, diabetes, AIDS and HIV continue to be a rising concern for the Aboriginal community (Aboriginal Health Policy Branch, 1994).

The following is a brief list of some of the social trends that drastically influence the health status of Aboriginal women. Although these come from a national source, these are readily observable in the women that I see in my workplace (Statistics Canada, 1995).

\*Aboriginal women have higher fertility rates than non-Aboriginal women. One result of this is that they tend to have more children living at home than other women. In 1991, there were 4214 children per 1000 ever married women with multiple Aboriginal origins compared to 2399 per 1000 non-Aboriginal women. Among two spouse families 23% of Aboriginal women had three or more children, compared with 14% of non-Aboriginal women.

\*Aboriginal women tend to have less formal education than other women in Canada. Less than half as many Aboriginal women compared to non-Aboriginal women have a university degree. At the same time, Aboriginal women are more likely than other women to have less than a high school diploma. In 1991, 6% of Aboriginal women 15 years and over had a university degree compared to 13% of non-Aboriginal women.

\*Aboriginal women are less likely than other women to be employed. In 1991, 47% of Aboriginal women were employed compared with 54% of non-Aboriginal women.

\*As with other women a large proportion of Aboriginal women have part time jobs, in areas typically filled by women such as clerical, service and sales jobs.

Aboriginal women are less likely than other women to be employed in professional and managerial positions. 12% of Aboriginal women are in professional positions compared with 15% of non-Aboriginal women.

\*Aboriginal women are more likely than other women not to participate in the labour force. That is, they are neither employed nor looking for work. In 1991, 40% of Aboriginal women 15 - 64 years of age did not participate in labour force compared to 30% of non-Aboriginal women.

\*The average employment earnings of Aboriginal women are lower than those of other women in Canada. In 1990, the average full-time full-year earning for Aboriginal women was \$23,800, over \$2000 less than their non-Aboriginal counterparts. Employed Aboriginal women also earned less than Aboriginal men in all age groups.

These trends illustrate the conditions for many Aboriginal women in Canada. If nothing else, they make the reader ask: Why? It is justifiable that one would want to explore the issue of culture, to see if it holds any clues or answers that might address these staggering statistics. These social trends tell us that we must look beyond what we stereotypically think of as culture, beyond the ethnic food and the arts and crafts. It has been identified that a "state of best health is not merely a function of personal capacity, but is also closely related to a whole set of personal resources" (Standing Committee on Health, 1995). These resources include the cultural beliefs, values and systems that reinforce or undermine individual behaviors and choices.

As health care providers we must look at the real issues that exist for our clients and confront them head on. Our caring nature must extend beyond the pat on the hand and reassuring looks. We are in critical positions to deeply connect with other individuals on a meaningful level that transcend cultural barriers and boundaries.

## **The System**

Research suggests various reasons for the high incidence of disease and ill health in the Aboriginal population. "Suppression of cultural traditions, language, and spirituality combined with a depressed socioeconomic situation have created an apathy so deeply embedded in the psyche of Native Americans that many attempt to escape reality through alcohol, drugs or suicide" (Klyde, 1994, p. 701). The Canadian Nurses Association says that "Aboriginal health problems are rooted in the past and current socioeconomic conditions...damage caused by the historical abuses of Aboriginal cultures....which include suppression of Aboriginal spiritual values, education in residential schools and the loss of a hunter gatherer lifestyle..." (Shestowsky, 1995 p. 24).

An "idiom of loss" has been expressed by Aboriginal women in regard to the level of distress they feel (Willms, Lange, Bayfield, Beardy, Lindsay, Cole and Johnson, 1992). This sense of loss is imbedded in relations and systems of accountability, there is loss of moral relations with persons, with community and with the land (Willms, et al., 1992).

Other research identifies specific barriers that exist within the health care system and society that may contribute to the issue of difficulty with access to good health care. Gurunge and Donner (1996) discuss transcultural nursing in Canada generally and identify several common factors among the health care experience of members of ethnic minorities. Many feel they have no voice in the care process, clients may be viewed as unco-operative because of communication difficulties (this extends to both literacy and verbal communication), they may encounter discrimination and judgmental attitudes that make their experience less than positive, the nurse's conscious or unconscious



ethnocentrism may interfere with full rapport building, and differing cultural values may be seen as contributing to health problems or non-compliance with prescribed treatment.

Shestowsky (1996) goes further to identify several structural and attitudinal barriers specific to urban Aboriginal populations that also limit access: lack of information on availability and access to health care services, limited access to traditional healing systems, and the absence of translation services for Aboriginal languages. The issue of socioeconomic determinants of health also contributes heavily. Social upheaval, drastic lifestyle changes, poverty and lower education levels are also identified as having a major impact on the lives and health of Aboriginal women. (Hatton, 1994; Lea, 1994; Sokoloski, 1995).

The Canadian Nurses Association reiterates these structural barriers in its 1995 report, *Health in Canada, Perspectives of Urban Aboriginal People*. They identify poverty as a major contributor to the social and health problems experienced by urban Aboriginals. Malnutrition and poor housing are direct results of this. Complex restrictions and policies related to Indian status and health care also make universal access ironically unattainable. The federally funded non-insured health benefits such as glasses and dentistry are available only to those identified as having status. Metis, Inuit and non-status Indians do not qualify. This ineligibility combined with the prevalent depressed socioeconomic situation makes for tenuous access to what is considered a right for some. The CNA also identifies poor communication across cultural lines, influenced by language and attitudinal barriers as a contributing factor. (CNA, 1995)

There is a fundamental difference in the way in which sickness and health are

viewed in the traditional Aboriginal community as compared to dominant society. The current health care policies of the government contain a bias that represents health care seen in individual terms rather than in the context of society or as a result of the actions taken by vested interest groups such as the Canadian Medical Association. (Frideres, 1994) This individual focus results in technical solutions to health problems being offered and social, economic or political cues being ignored. (Frideres, 1994; O'Neil, 1989)

"Culture creates rules of behavior for its members, dictating what is expected, encouraged or allowed." (Frideres, 1994, p.215). Native people whose culture is tightly reinforced among one another may have accepted attitudes towards illness and a strategy for dealing with it that are a direct result of how their culture defines it and the social pressure or support to conform to those cultural norms. (Frideres, 1994). An example might be the accepting attitude that they may adopt when they discover they have a medical condition that they can neither prevent nor heal. They learn to define a medical condition not as an illness but as a state of being and therefore require no health care services. They become labelled as 'non-compliant' by the middle class medical professional whom do not understand the lifestyle of their native patients. Professionals assume perspectives on illness are the same as their own and that they have the same resources or access to the same resources (ie: economic, political, educational) (Frideres, 1994). This of course is not true, but is often the source for stereotyped impressions of native people being dirty or irresponsible.

Critical social theorists also attribute the inequities in the healthcare system to the

differential in power structures. On a societal level, native people lack participation in the system's decision making processes and in effecting change in health policies (Shestowsky, 1995). Individually, the relationship between the health care provider and client is inherently fraught with power struggles. Ownership of the modern health care knowledge valued by society confirms the validity of the provider's words and reduces the power of the client's perspectives. Superimpose this power relation on an already disempowered group and there is a chasm created that alienates native people further. The social class differences created by economics plays heavily into this (Lea, 1994).

In summary, given that Aboriginal culture is no longer intact in its purist form and given that its existence has been altered and influenced by the forces discussed, we must ask if there is still a place in which to consider culture in the process of caring for Aboriginal people. It is important to discuss what care looks like for Aboriginal women, given the cultural issues identified previously and the recognition of the need to provide culturally sensitive care.

## Care

Current research says that cultural ways of knowing and the values that people hold definitely influence the way people experience healthcare (Anderson, 1986; Crow, 1993; Lea, 1994; Sanchez & Plawecki, 1996; Turton, 1997) How people perceive, experience and cope with disease is based on their explanations of sickness, or lay view of ill health (Kleinman, 1978). Turton goes on further to identify it as a "health world view" (Turton, 1997). She says that "a health world view is a cognitive orientation or

overall way a culture looks at health and well-being, illness, and aspects of death.....this culturally influenced view is widely shared among members of a cultural group and plays an enormous role in their understanding of that world and their behaviour in it' "(Quinn & Holland, cited in Turton, 1997, p. 30). Based on this research, there is arguably an important role for cultural considerations in the delivery of care.

Where does one start? Health care providers often become confused when considering exactly what cultural awareness means. They may draw on their own frame of reference for cultural symbols and values. It is not uncommon for nurses or health care providers to believe that they really don't have a culture (Crow, 1993; Habeyeb, 1995). However, this statement actually demonstrates a lack of awareness of the forces that contribute to personhood. As members of the dominant society, their cultural norms are so completely integrated into societal structure that membership in a distinct culture is difficult to perceive. It is only when confronted with incongruent cultural norms that differences among peoples becomes strikingly apparent (Lea, 1994). For members of minority cultures, this difference manifests itself in a struggle to function within the dominant infrastructure. This struggle may also reinforce doubts one may have about one's own culture.

In a practical sense, this means that all our interactions as professional health care providers are affected by both the world view of the patient/client and those we hold ourselves. This becomes strikingly clear when the cultural norms of others are violated either outright or by omission. Care providers are struggling with "the idea that cultural ignorance or insensitivity can neutralize the positive outcomes of care interactions."

(Sanchez, Plawecki & Plawecki, 1996 p. 296). They refer to this as *cultural collision*.

The formal use of the term "transcultural nursing", is attributable to the nursing theorist Madeline Leinenger and her Culture Care Theory. I am, however, using this term to describe the whole movement by health care providers to think about their clients/patients' individual needs culturally, and provide care that is congruent with that culture. Leinenger (1991) describes culturally congruent nursing care as "those cognitively based assistive, supportive, facilitative or enabling acts or decisions that are tailor made to fit with individual, group, or institutional cultural values, beliefs, and lifeways in order to provide or support meaningful, beneficial, and satisfying health care, or well-being services." (p. 49) Simply put, in order to truly provide *care* for the client, his or her cultural perspective must be valued, the care giver must go beyond their own cultural limitations and the interventions or facilitation must be congruent with those values held by the client. Nurses are instructed to "transcend their own cultural orientation and view the patient through the patients' cultural lens" (Gagnon as cited in Lea, 1994).

Research done on Aboriginal people has predominantly concentrated on identifying cultural norms or practices of specific tribal groups such as Navajo, Ojibwa, Coast Salish or Cree (Clarke, 1990; Dempsey & Gesse, 1995; Sanchez, Plawecki & Plawecki, 1996; Sobralske, 1985; Strickland et al., 1996; Turton, 1997; Willms et al., 1992) or on how those norms influence a specific health condition or concern such as diabetes (Daniel & Gamble, 1995; Goforth Parker, 1994; Murphy, Schraer, Thiele, Boyko, Bulko, Doty, & Lanier, 1995), pregnancy (Clarke, 1990; Dempsey & Gesse,

1995; Duffy, Bonino, Gallup, Pontseele, 1994; Sokoloski, 1995), or cervical cancer (Hislop, Deschamps, Band, Smith, Clarke, 1992; Stillwater, Echavarria, Lanier, 1995; & Strickland et al., 1996). One of the conclusions of all this research is that the premise of providing culturally congruent care is prudent and will improve the health care context of the target group.

The intention of culturally sensitive care is genuinely good, I believe. However, there is something within me that resists the notion that by knowing a list of features of textbook North American Indians, the care provided to this group of people will improve. Klyde (1994) says that "to guarantee success in health care delivery, all clinicians should know how patients view themselves as part of the community and the universe..." (p. 705). This statement may seem a bit naive since the very idea of guarantees existing in life is suspect. Plawecki (1992) states that "recognition of the cultural / traditional healer or spiritual leader of a community by the health professional may facilitate patient co-operation and compliance....communicating with traditional health practitioners and religious leaders demonstrates respect for community values and may facilitate support for resolving other health-related issues." (p.5) These statements in themselves are well intentioned and when spoken by someone genuinely interested in Aboriginal people would pose no threat. What I find disconcerting is the potential for culturally sensitive care to become a recipe or method for practitioners who simply want to maintain the power in the relationship and achieve their defined professional goal. The knowledge gained through cultural education should not be used to give the practitioner an edge in manipulating the care relationship. The risk of exposing cultural knowledge is always

the safety of those who have given it away. It disturbs me slightly that there are research articles written on such sacred ceremonies as the Peyote ceremony of the Native American Church (Huttlinger, & Tanner, 1994). It serves no purpose to have the ceremony written about publicly other than to satisfy the curiosity of those who may read it. Would it not suffice to describe the implications of the ceremony and the meaning of its power for the people who participate? It seems unsafe that the article, once written, may then be distributed and utilized in ways for which it was not intended possibly resulting in lack of respect for the ceremony.

The other concern I have about cultural research is its applicability and generalizability. Habeyeb (1995) discusses the many complex issues of doing cultural research including cultural diversity. She cites Tripp-Reimer, in her article (1995) as stating "cultural studies are not predictive at an individual level"(p. 226). This is a point of concern. I believe that what is concluded at a macro level may vary greatly with what a practitioner may expect at the individual level. For example, I do not know where the statement that "native people consider direct eye contact a sign of disrespect" (Lea, 1994) originally surfaced, but throughout my career I have heard and read that countless times from knowledgeable non-native people. In my early years as a new graduate nurse I remember distinctly a nurse educator, who thought I was non-native, telling me not to look any of my clients in the eye. So I didn't. After about a month, the woman I was working with on the reserve asked me if I did not like her, or was afraid of her because I refused to look at her. She said she thought I was just shy at first, but now she was beginning to mistrust me. The same holds true for my own experience as an Aboriginal

woman entering the health care system. I know that if I were to encounter a practitioner who had just finished reading an article about avoiding eye contact and upon seeing me refused to look me in the eye I would be uneasy in the relationship and wonder why she/he was unable to connect with me.

Turton (1997) in her research describes the Ojibwa as "intensely religious and fiercely independent" (p. 31) Really? All of them? Are there not any pagan or non-religious Ojibwa people left or did the church get them all? Inherently I know what she means. She is referring to the influence of the organized Christian church via the missionaries and its profound impact on Aboriginal people to the extent that much of the Christian doctrine and spiritual rituals have been assimilated into the culture. It worries me to think, however, that someone who may not know the whole history of the Christian churches' influence on Aboriginal peoples may read that statement and think that Christianity was adopted wholeheartedly, or worse yet, not to think about it at all and simply accept it as fact when there are many facets to that statement. I also question its validity in today's society where many Aboriginal youth are tending to either vehemently oppose the paternalistic and oppressive nature of government and church institutions, or simply passively avoid its influence by no longer taking part in its rituals.

It is evident how difficult application of cultural research done on a group level might be on an individual level. In the article on cultural competence (Absolom, Beil, Kavanagh, and Schliessmann, 1999), the authors specify succinctly that a nurse who is culturally competent would discern "both patterns and variations, deftly avoiding stereotyping and overgeneralizing while becoming committed to hearing, seeing



experiencing and learning with as little bias as possible" (p. 19) It is reasonable to state that the danger of stereotyping is always there. If people lived in a vacuum where culture and lifestyle remained static, then we might be able to assume that the traditional view of things may be still intact. In the year 2000, however it would be naive to think so. When research regarding this phenomena is examined, it should be done with an informed lens, so as to take into account the impact of urbanization, colonization and societal influences. "Recognizing and acknowledging diversity within a group, which is often as great as that between groups is a major part of learning and connecting." (Absolon et al., 1999, p.19)

An example of how these many influences may manifest themselves are in the findings of Sokoloski's study (1995) on First Nations' beliefs about pregnancy. She states that traditional values are identified and espoused among the women as ways to guide their health during pregnancy, *but may not be acted upon*, thus creating a situation where their birth outcomes may be unhealthy. Why are they not acted upon? This is a key question for researchers to focus on. The traditional values are identified, spoken, intellectualized and then published but no change in health status occurs. Where is the gap between what the traditional world view holds as important and what gets played out in the lives of these women? Are these beliefs espoused because that is what the women feel the researchers want to hear? Or are they beliefs that have been abandoned in practice, and substituted by the hope of accessing the more modern ways of their urban white neighbours?

It is not an easy task to provide care to another individual. Add to that the consideration of another culture and the task may become even more daunting. Jean

Watson, in her book: *Nursing: Human Science and Human Care, A Theory of Nursing*, discusses what her goal of the care process in nursing is:

The goal of nursing proposed is to help persons gain a higher degree of harmony within the mind, body and soul which generates self-knowledge, self-reverance, self-healing, and self-care processes while allowing increasing diversity.

The goal is pursued through the human-to human caring process and caring transactions that respond to the subjective inner world of the person in such a way that the nurse helps individuals find meaning in their existence, disharmony, suffering, and turmoil and promotes self-control, choice, and self-determination with the health-illness decisions (p.49).

Watson summarizes what I believe the health care provider needs to consider when interacting with any client, including Aboriginal women. She states that nurses need to help the other "find meaning in their existence, disharmony, suffering, and turmoil..."(p.64) which for me encompasses considering the culture of another, or the state of being that they bring to the relationship. Watson later states that a caring moment encompasses the "ability of the nurse to assess and realize another's condition of being in the world..." (p.64) This goes beyond what can be attained by simply relying on the list of cultural values and traits that may be gleaned from research. This involves understanding society, the history, the social conditions and the ways of Aboriginal women.

Giger & Davidhizar (1997) have proposed a model to be utilized when interacting with those clients of other cultures. They specify that in a "multicultural society nurses need to be prepared to provide culturally appropriate care for each client regardless of that client's cultural background" (p.26). Their model is to be used as a tool to evaluate cultural variables and their effects on health and illness behaviors (Giger & Davidhizar, 1997). They have identified six cultural phenomena which they say vary with application and use and yet are evident in all cultural groups: communication, space, social organization, time, environmental control and biological variations (Giger & Davidhizar, 1997).

These variables are concrete descriptors that can be utilized to begin discussion, inquiry and communication between health care providers and clients. However reluctant we may be to step outside our ethnocentric safety zone, it does seem imperative that we begin to identify and collapse those societal barriers that exist for Aboriginal people in this country.

Browne (1995) has explored the concept of respect in terms of delivery of care services to First Nations people. She has defined respect using six characteristics defined through her interviews with the Cree-Ojibwa of Northern Manitoba. Those characteristics are:

- 1) Capacity to treat people as inherently worthy and equal in principle
- 2) Acceptance of others
- 3) Willingness to listen actively to patients
- 4) Genuine attempts to understand patients and the unique situation of each
- 5) Attempt to provide adequate explanations
- 6) Sincerity during interactions (pp.101- 103)

Browne's research also identified several things which the respondents felt resulted in lack of respect in a health care interaction. They were:

- 1) Lack of respect stemming from discriminatory attitudes
- 2) Failure to consider patients perspectives
- 3) Failure to provide privacy for patients
- 4) Failure to provide adequate explanations
- 5) Negative nonverbal behaviors (pp.104-105)

Both of these lists of positive and negative indicators provide insight into what is perceived as good or bad health care experiences. Both lists are based on what the group that the researcher interviewed deems as important values and characteristics in an interaction. This article, in fact, touches on my own research question and the concept of culturally sensitive care. Just what is it that Aboriginal or albeit all of us want in a health care experience? I would venture a guess that we all want to feel valued and respected. Much of the nursing literature refers to the noble goal of enhancing our practice by providing culturally sensitive care, but few put forth concrete examples of how to do this or what it actually means in an applicable sense.

Absalom, Beil, Kavanagh, and Schliessmann (1999) discuss what they term *cultural competency*. They relate the experiences of nursing students attending a field school on the Pine Ridge Reservation in South Dakota and their process of learning through cultural immersion and their subsequent process of connecting with the people of the reservation. Interestingly, this article does attempt to offer some concrete examples on how one can achieve a state of cultural competence and the process that their field school supported. The authors also identify the process as being as important as the

outcomes. Their findings reveal "intercultural connecting to be directly related to the investment of time and commitment to establishing and pursuing meaningful dialogue" (p.13) This statement fits with the results that Browne identified as being important to the Cree in Northern Manitoba, which was that of genuineness in the attempts to understand patients and the unique situation of each. (Browne, 1995)

I support any move in that direction that can be facilitated by making health care providers more culturally sensitive through use of models, immersion field studies or by simply reinforcing these characteristics of respect. It is clear, however, that more research needs to be done on this subject of providing care to Aboriginal populations. There is more to hear from Aboriginal people themselves and Aboriginal women in particular.

It is my hope that through my research I have been allowed to tap into the spirits of Aboriginal women and am presenting their lives and their experiences with the health care system in such a way as to reach out to the reader. I am only a conduit through which these Aboriginal woman can touch the health care system and its providers, with their stories of their lives, families and struggles. I am attempting to go beyond what simple words can say to a place where their stories will allow the reader to learn and to engage in further exploration of models and tools for cultural assessment, but more importantly it is my hope that the reader will *think*.

## **CHAPTER 3 METHOD**

### **Procedures for the Study**

I chose hermeneutic phenomenology as the method to help guide my exploration. Phenomenology presented me with a way to get at the essence of the individual experience of the situation reflected in my research question. Hermeneutics generally is "the theory and practice of interpretation and understanding in different kinds of human contexts" (Chesla, 1995). This simple definition centers on two key concepts that reflect my interest: understanding and interpretation. On a personal level, I am motivated to make sense of my experience as a starting point for further study, which is congruent with the phenomenological method, and on a professional level I feel that I am strategically positioned to aid in the interpretation of this phenomena.

Within the phenomenological paradigm, there is a premise that humans 'are situated'. Chesla (1995) identifies that "humans are situated within meaningful activities, relationships, commitments, and involvements that set up both possibilities and constraints for living....(they are) living within a complex of understandings about the world and ways of being and acting in the world that are available in that particular time in history, in the culture and in the family in which they find themselves." An example might be the process of getting to know someone. I want them to tell me of their life and their experience. In the same fashion, I want to be known by the experience that I have lived. I want credit for my life and acknowledgement that it is important and meaningful. These past lived experiences make us who we are, in more than just chronology or history. Our experience allows us to become, to endeavour in the process of being. I

want someone to truly *know* me. When I write a paper or a poem or a story, I am opening my living being to the others in the world. I am trying to transmit an understanding of myself through illustrating my situatedness in the world. I want to be able to open the door to the living experience of others. I want to reveal their situatedness in the world and be with them in their experience. Although I cannot truly walk a mile inside their very own shoes, I can, by the processes of interviewing, bracketing and reflexivity, interpretation and writing attempt to find the essence of meaning for the women who's experiences I have chosen to study. Phenomenology is attempting to guide the researcher to the truth as it presents itself in the reality of the day.

Using the phenomenological method has required me to examine and get to know myself as well as the women I interviewed. Phenomenology directs the researcher to bracket out or identify assumptions, biases and personal situatedness in an attempt to increase the academic validity of the research as well as decrease any unintentional interference in the interpretation process. As identified by Hirsh, in van Manen (1997), "understanding is a dialectical process between the reader and the writer." (p.180) Hirsh argues that "the validity of any particular textual interpretation is increased by knowing something about the person who wrote it"(p.180) Thus the section on my own Personal Journey/Situatedness, although lengthy, is quite critical to the use of this method.

Finally, van Manen (1997) describes hermeneutic phenomenology as trying to "be attentive to both terms of its methodology: It is a descriptive (phenomenological) methodology because it wants to be attentive to how things appear, it wants to let things speak for themselves; it is an interpretive (hermeneutic) methodology because it claims

that there are no such things as uninterpreted phenomena. The implied contradiction may be resolved if one acknowledges that the (phenomenological) facts of lived experience are always already meaningfully (hermeneutically) experienced. Moreover, even the "facts" of lived experience need to be captured in language (the human science text) and this is inevitably an interpretive process.

This definition of phenomenology helps me to clarify my struggle with interviewing the participants of the study. I tried to identify questions that would enable the women to describe their experience without providing an analysis of the situation. This proved very difficult to do. Our way of being as people and of using the English language lends itself to interpretation. Although, I did not give up on my attempts to elicit simple description from the women, it is clear to me that interpretation-free discourse is impossible. Language and the process of remembering naturally invites us to lay down meaning on our experiences.

### ***Participant Selection***

I chose to use criterion purposeful sampling to select the participants for this project. This means that all the selected participants must have had experienced the phenomenon of interest. My participants are Aboriginal women over the age of nineteen who are English speaking. They have all accessed a health care service designed or targeted specifically for a native population, specifically Tsewultun Health Center of the Cowichan Tribes. I designed a poster (see Appendix A) to advertise for participants in the study and advertised by simply placing it on the bulletin board at the health center.



As well, I let it be known to my colleagues at work that I was trying to find participants and would welcome their suggestions and or contacts.

I interviewed four women. Two of the participants responded to the poster, one came through a recommendation from a colleague and one woman was invited to participate through my own identification. I met with each participant to explain the purpose of the project, risks of disclosing information and obtain informed consent. We subsequently arranged one tape-recorded main interview and one follow-up contact to clarify information gained in the main interview.

### *Data Collection*

Written and informed consent (see Appendix B) was obtained prior to each interview. The main interviews lasted approximately an hour to an hour and a half, depending on the participant. We held all the interviews at the health center during my time off work. All four initial interviews were tape-recorded. Subsequent clarification interviews were not tape recorded, but notes were taken by hand during the process. The main interviews began with a recap of my research and a general plan of what was going to happen. This was followed by general unrecorded questions about the participant, such as "How are you feeling today?", "Is there anything going on for you that might influence how this session will go?", "Do you have any questions about this whole process?" I wanted to make the participant feel comfortable and reassure her of what my intent was.

The interview questions were very open ended in an attempt to get at the

experience of the participant and not her or my interpretation or explanation of that experience. As best I could and without unduly constraining her, I had hoped to try to explain at the beginning of the interview how to speak about a lived experience. Van Manen (1997) discusses this aspect of interviewing and lists these points as possible guides in producing a lived experience description:

- 1) You need to describe the experience as you lived through it. Avoid as much as possible causal explanations, generalizations, or abstract interpretations. For example it does not help to state what caused your illness, why you like swimming so much or why you feel that children tend to like to play outdoors more than indoors.
- 2) Describe the experience from the inside, as it were; almost like a state of mind: the feelings, the mood, the emotions etc.
- 3) Focus on a particular example or incident of the object of experience: describe specific events, an adventure, a happening a particular experience. (p. 64-65)

I found that in the first interview I ended up confusing the participant by trying to tell her how to answer and she was most hesitant before speaking. For subsequent interviews I opted not to employ this preamble, but tried to be conscious of it when thinking about my line of questioning.

An example of the first questions that I asked everyone was: "Tell me a little bit about who you are" or "I'd like you to describe yourself to me". From that point on subsequent questions were based upon the response that the women gave me. It was impossible to completely plan the interview because so much of it depended on outcomes of questions and the woman's ability to articulate her experience (See Appendix C, for original planned interview questions).

All taped interviews were transcribed. I spent a great deal of time simply

reviewing transcripts. I read certain passages over several times to see if I could get a feel for the words. At several points in the process of reading, I felt compelled to write poetry to express what I was getting from the data. I found this process to be somewhat distracting but also somewhat helpful in compiling my thoughts. Overall, although somewhat a departure for me from my usual writing style, I found the process of writing poetry to be quite freeing and it allowed me to focus more on the analysis and findings.

### ***Ethical considerations***

The two main ethical considerations involved in this research project were that of *confidentiality and risks to the participants*. During the initial set up interview while obtaining informed consent, I discussed with the participants all the measures that were in place to assure confidentiality. I explained that their identity would be kept confidential through the use of pseudonyms. All tape recorded data would be kept in locked cabinets at my home until the project was complete at which time they would be destroyed. Written transcripts were also kept in locked cabinets along with any data on diskette. The exception to the secured cabinet was the data where only pseudonyms were used that was on my hard drive of my home computer. The participants were also reassured that only my supervisor and I would have access to the tape recordings.

The participants were informed that specific situations may arise where confidentiality would need to be breached. Those may have included instances where situations were disclosed that required follow up, such as suicidal tendencies on the part of the participant or verbalizations regarding child abuse, severe depression, or illegal

activity which could result in injury to myself, the participant or others.

The risks of participating were also discussed in relation to these possible situations. I explained to each participant that although I would maintain confidentiality to the utmost of my ability, I was still operating within the guidelines provided for me as a professional nurse and so had the responsibility to act on anything that I thought required follow up. An example of this is that although a participant may not be ready to address an issue of domestic abuse through counselling or legal action, there was potential for me to recommend that course of action if I learned through the course of our interviews that the participant required intervention.

I was also aware of the fact that I was continuing to work as a nurse in the community and did not want my thesis work to interfere with that. I did not want a formal interview process to influence the nurse-client relationships that I had with anyone or to confuse them about my role at any given exchange that we had. For this reason I chose participants that I did not know very well or had not worked with on a regular basis. I emphasised to the participants and to the ethics committee that there would be no possible negative impacts on the client if she should choose to participate or if she should choose to withdraw at some point in the process.

### ***Data analysis***

The phenomenological method involves a particular type of analysis. Van Manen (1998) describes phenomenological reflection as trying to "grasp the essential meaning of something." (p. 76) He goes on to say that,

" the meaning or essence of a phenomenon is never simple or one-dimensional. Meaning is multi-dimensional and multi-layered....human science meaning can only be communicated textually by way of organized narrative or prose. And that is why the human science researcher is engaged in the reflective activity of textual labor. To do human science research is to be involved in the crafting of a text. In order to come to grips with the the structure of meaning of the text it is helpful to think of the phenomenon described in the text as approachable in terms of meaning units, structures of meaning or themes. Reflecting on lived experience then becomes reflectively analyzing the structural or thematic aspects of the experience." (p.78)

In the transcribed text of the interviews, I conducted what van Manen describes as *thematic analysis*. Themes refer to an element or unit of meaning which occurs frequently in the text. "Theme analysis refers then to the process of recovering the theme or themes that are embodied and dramatized in the evolving meanings and imagery of the work." (p.78) The process which I used is called the *detailed or line by line approach*. Using this process, I looked carefully at each sentence in the transcribed text and tried to discern what the sentence revealed about the phenomenon or experience being described. As I went through the entire transcribed text, clusters of themes emerged. These clusters are the basis for my analysis and interpretation of the meaning. This method was tedious and time consuming, but provided me with comprehensive and accurate results that were true to the lives of the women.

I began the analysis by writing down every word or phrase that I thought had some independent meaning. This resulted in pages of written phrases and single words. I continued by looking at this resultant data and resumed my line by line dissection, again writing down further units of independent meaning. This part of the process involved

some of the interpretive judgements that I thought would not be required until I was in the "analysis" phase of the project. As I realize now however, the whole process of phenomenological research involves experiencing and interpreting, going back and checking perceptions and then forward and interpreting further. It is impossible to be devoid of interpretation when the very nature of our written word is a constructed way of interpreting the experience or phenomena being examined.

My third run at the data began to produce some common themes. The same words showed up again and again. Ideas or meanings that the women described were repeated either throughout the interviews or by several women. From this, I began to organize the data into clusters of meaning or sub-themes and finally into themes. These themes are listed in the next chapter on research findings.

Results of the study are summarized using quotations and excerpts from the transcribed record as examples of the themes. In my writing of the findings of the study, I have included a small amount of poetry written by other authors as well as myself that I think helps to illustrate my interpretation of the data. Linda Richardson (1994), in her article on writing qualitative research, discusses the process of writing creatively as a way of presenting findings from research. She describes experimental representations as, "violating prescribed conventions in social scientific writing and as being somewhat compatible with the postmodernist context. Within this context there is no such thing as "getting it right", only "getting it" " (p.521) Even if the final document is in a more conventional format, the process of experimentation with different forms is a practical and powerful way to expand one's interpretive skills. (Richardson, 1994) Poetry is one

genre of experimental writing that aids in attempting to "recreate lived experience and evoke emotional responses." (p. 521)

I found this a most powerful way to recapitulate the meanings that were emerging for me. I agree that when creative material is used in research there is a risk of altering the intended end. In this project, however, I have taken that risk and felt that if used appropriately and conservatively it can only enhance the findings and interpretations. It is my belief that the total lived experience is more than can be communicated in a prose format. It is naive to think that our academic research language skills could be enough to capture the essence of anyone's experience. I do truly believe that in human science research, such as mine, gravitating towards the poetic word in order to help explain the phenomenon which is being articulated by the women is of critical importance.

### ***Rigor***

Academic rigor is usually thought of as quality control in research. How does one ensure that what you are studying is in fact rigorous research? The accepted procedures for ensuring reliability and validity that are so valued in quantitative research do not easily transfer to qualitative research. In qualitative research, parallel questions are asked relating to these concepts. Most qualitative researchers agree that the language of "positivistic research is not congruent with or adequate to qualitative work" (Creswell, 1998, p. 197) The terms that are found in the discussions of rigor include such things as credibility, transferability, confirmability, triangulation, crystallization etc. (Creswell, 1998) In the phenomenological tradition specifically, researchers view the standards of

rigor primarily in relation to the researcher's interpretation of things. How is his/her lens affecting the outcome of the analysis? What procedures can one use to ensure that these perspectives are identified? Moustakas (cited in Creswell, 1998, p. 207) says that "establishing the truth of things" begins with the researcher's perceptions. He goes on to say that "one must reflect first on the meaning of the experience for oneself; then, one must turn outward, to those being interviewed, and establish "intersubjective validity," the testing out of this understanding with other persons through a back-and-forth social interaction." (p.207)

For this study, I engaged in several procedures throughout the research process to ensure that academic rigor was maintained and that the results are in fact credible. They included: 1) Prolonged engagement and persistent observation 2)Peer review 3)Clarifying researcher biases 4)Member checks and 5)Rich thick description.

### *Prolonged Engagement*

Prolonged engagement and persistent observation includes "building trust with participants, learning the culture, and checking for misinformation that stems from distortions introduced by the researcher or informants." (Creswell, 1998, p.201) This means that during the process of interviewing, consideration must be given to the impact of the study on the participants and the feelings that may be incurred during disclosures. The kinds of information discussed are highly dependent on the early establishment of trust and safety, as well as underscoring the solidarity that could exist between researcher and participant because of our shared experiences as native women. It also refers to the



process of engaging in several interviews with the participants gradually building and clarifying the data in each subsequent visit.

In this project, the process of engagement happened relatively quickly. Most of the women knew of me or had seen me at the health center and may have even interacted with me in some other brief capacity prior to our actual interview. All the women appeared very comfortable from the moment we sat together.

I initially met with each woman for a set up and clarification interview. At this time we shared some basic demographic information and talked a little bit about where we were at in our lives. I chose to share information about my life at this time and let each one know who I was and about my family, demands, and work. I found this an important part of getting to know the women. Two of them had seen me around the health center and knew that I was native and were curious about who I was or might be related to. Although I had originally thought that the set up interview would be very business like, explaining details, consent procedures etc, it was not. It played a key role in establishing trust. I did not have the tape recorder at that time, and there were no obligations placed on either of us. I was able to just sit and visit with each of the women and get a sense of who they were and whether they were interested in what I was doing.

I want to say that I feel that the trust building was much easier for me because I was native than it may have been if I was non-native but I am uneasy and unsure about this statement. I remember one woman saw a book that I had with me entitled, *A Tortured People, the Politics of Colonization*, by Howard Adams. She immediately asked if "that Howard guy was an Indian, I am tired of white people writing about us."

This speaks to me about a lot of things, but one in particular is the perception that native people should be doing work about/with native people. This principle is not really supported in the findings of my project per se and yet it is a point that I have heard made many times and believe myself to some degree. It may be that some native people do have a preference for other native people in specific instances or maybe it is just the moment of first contact in a new situation that is helped by the familiarity of another brown face. Whatever actually went on, I feel that my native ancestry was a beneficial tool in this part of the process.

A related issue to the physical identity is that of an insider's knowledge of the culture. In prolonged engagement, one of the goals is to learn the culture of the individual. In this instance, the use of the word culture does not mean specifically ceremonial or traditional cultural practices, but it refers to the general milieu that is specific to the individual. It points to gaining an understanding of the environment or social situation that constructs the individual's reality. In this regard, I had some sense of solidarity with the women I interviewed, not only because of my nativeness, but because of my experience with racism and the impacts of colonization. I had also worked with the community for several years and felt I had a general understanding of the ways of the community. This eliminated the need to spend long periods of time getting to know the milieu and culture through a discussion process with the participants.

If anything interfered with the trust building process it was the mechanics of tape recording. Most of the women found it somewhat uncomfortable to know that they were being taped during the main interview. Initially, there were some stammers and long

pauses as we established a rhythm of conversation and questions, but eventually some level of comfort resumed. This was evident by the way the click of the tape recorder startled all the women as it clicked off when a tape was full.

### *Peer Review*

Peer review or debriefing provides "an external check of the research process" (Creswell, 1998,p.202) through having the peer reviewer "ask hard questions about the methods, meaning, and interpretations" as well as "providing the researcher with the opportunity for catharsis by sympathetically listening to the researcher's feelings." (p. 202) This step in the process was one of the most valuable for me but also the most difficult. To ensure confidentiality, I chose someone who is unfamiliar with the community that I am working in but who is familiar with the issues relevant in the Aboriginal world. I established contact with an Aboriginal nurse that I know in a professional context who has been very willing to hear me out. She read excerpts of my thesis in draft form and commented on the contents. This was a difficult thing for me to do. It is one thing for me to give my writing to a professor, for they are my superior in a sense. Giving my writing to a peer is much riskier. I had to let my ego needs go and allow peer feedback to engage me in thinking and not necessarily in feeling only. If I did have strong immediate feelings, I had to think these through and analyze where they were coming from and if they were connected to an issue that related to the paper or not.

My fears stemmed from an insecurity about my ability to write, not only relating to the style and format but also the actual content of what I was discussing. I am often

inside my own head and end up thinking that I am creating all my own issues or that I am making too much of an issue and that it doesn't actually exist in the real world. As I will discuss later, I also found my journaling helpful in this regard.

My peer reviewer would take some time to read a portion of the paper and then get back to me with her comments. Sometimes there were just typos and minor grammatical errors, and other times she would be so animated about an issue that stirred in her she would phone me immediately after reading it. We tended not to discuss specific parts of the paper as much as we did issues within it. An example of this is the assumption that I articulated in the discussion on *Issues Embedded in the Study* about my belief that native nurses were better suited to work with First Nations' communities. This sparked a lively discussion between us and confirmed to me that it is indeed an issue in the real world and not simply inside my head. My peer reviewer has also struggled with this concept in the face of her own career choices and community demands.

Another issue for my reviewer was the placement and relevance of the poetry. She told me that on first reading she was a little skeptical of the reason behind the poetry. I had not explained anything to her and had not given her guidance about what to look for in the content. I had wanted her to read it with fresh eyes and an open mind. Her initial reaction was to say that it was unnecessary and superfluous. I was a little taken aback at the strength of her words, but after thinking them through I was grateful. Being challenged about the unorthodox use of creativity at this early stage was probably a good thing. I had to examine my reasons for doing this and evaluate whether it was truly enhancing or distracting. I had wavered on it myself when I was initially planning the

thesis, but having to defend its use early on solidified my stance about its relevance and importance. Another of the areas of discussion that my peer reviewer and I focused on a lot were the findings. She would continually ask me "what does this have to do with culturally sensitive care?" This question above all others has almost driven me completely crazy. I have made changes in the text to try to be clearer about drawing connections and illustrating meaning, based on my peer reviewer's constant questioning on this. At times I would be so frustrated thinking that "she just doesn't get it", and then after further thought I would realize that this is really a central issue in this whole project. Just what is culturally sensitive care and is the way we, as nurses understand or misunderstand it have any impact on the way a caring interaction is perceived by the individual receiving service? I had to think and rethink about this and about what the women were telling me. I know I would not have been so clear in my mind about what I was doing if I had not been "dogged" by my peer reviewer on this issue.

I also connected with members of my committee, especially my Advisor, Anita Molzahn, to steer me in the right direction as well as re-establish my commitment to the project. I became conscious of my need to debrief and discuss my work verbally when I became immobilized by apathy. I hit a point where I did not know where to go and felt unable to continue on with the process. I think that this is partly a function of being removed from the academic supports that exist on campus, but also partly from not recognizing progress that I was making. It is very difficult to see the progress yourself when there is no one around to substantiate it. I found it very difficult to maintain focus and motivation and would often lose my genuine interest in the subject. Knowing that I

would be accountable to my supervisor and ultimately to myself and the participants did influence my decisions to continue writing from a grounded place.

### *Clarifying Researcher Bias*

Clarifying researcher biases is crucial to all qualitative research but especially to phenomenology. The researcher bias must be identified so that the reader is aware of "the researcher's position and any biases or assumption that impact the inquiry" (Creswell, 1998, p.202). Phenomenologists attempt to bracket out or set aside their prejudgements and experiences and rely on intuition, imagination and universal structures to obtain a picture of the experience that is founded on a more certain basis. (Creswell, 1998) This, in practice, is an impossibility because as human beings we can never separate ourselves from our perceptions which are formed by previous experience, knowledge and values. It is important, however, that I identify my assumptions, preconceived notions, biases and ideas so that I as a researcher and you as a reader can attempt to analyze my data knowing what may be influencing me. I addressed this issue by identifying my situatedness in Chapter one of this paper.

I also found journaling to be quite useful in the continual reflection of my perceptions and interpretations. I would use my journal to write down a thought and then reflect on it a few days later. Often relationships to my value system would become obvious, or a connection with an assumption that I held would emerge. My preconceived notions were not always obvious when I was in the process of writing but allowing thoughts to mellow on the page and allowing the process of interpreting my thoughts

through creation of text is aided by the use of a journal. Re-reading my journal entries was like doing a mini thematic analysis which revealed a lot towards the bracketing of prejudgements. I will say more about the journalling process in a separate section.

### *Member Checks*

Member checks are where the researcher solicits informants' views on the credibility of the findings and interpretations. For my study, this involved taking the transcribed data, my analyses, and interpretations back to my participants for feedback on their perceptions of the process and confirmation (or otherwise) of accurate depiction of their experiences.

Of all the methods of ensuring rigor within my project this was probably the weakest. Although in phenomenology this is a very important part of the interpretation process, I was not able to connect on a level with the participants that I thought I should have. I don't know if all researchers feel this at the end of a project or whether it was unique to this situation but inherently there were a few barriers.

With each of the women I scheduled at least one follow up interview after the main tape recorded one to fill in the blanks in information and to check on details and meaning that I may have missed. At this time the women were still very interested in the process and seemed anxious to engage with me. The connection between us seemed to break down when it came time for checking in on the data analysis that I had generated. I found that it was very difficult for me to set up time to see the women. Their schedules were busy, appointments would be set up and then missed. I interpreted this a couple of

ways. I felt that because it had taken me such a long time to generate these written interpretations the connection that had been established with the women initially had lapsed. The other reason that I thought might be influencing the participants' willingness to get together were the very things that I had written about in my data analysis. The chronicity of chaos and structural barriers that exist in daily living were getting in the way of the participants thinking about anything other than survival. All the women have families and children who depend on them. They each have school or childcare loads that preclude them from leisurely contemplation about my thesis content. I was initially very worried that I was not meeting the rigor requirements until my peer reviewer said "don't take this on as your fault, reflect on it and discuss it in the paper. You can't make them do what they don't have time or interest in doing". An obvious statement, but one that I had not really considered.

Ultimately, I ended up speaking with them for differing amounts of time and with varied results. One of the women sat and nervously bit her fingernails while I went over the synopsis that I had written about her. She seemed uneasy when she saw the hard copy of the transcript of my discussion with her, and she was anxious for me to put it away. I needed to reassure her over and over that no one knew who I was writing about and that the themes were just my thoughts about our conversations and that I was open to comments about it. She anxiously agreed with me on everything and said that she thought it was "good".

Another of the women was eager to take a copy of the synopsis that I had written about her and the data findings that I had drafted out. Against my better judgement I



gave them to her and we agreed to meet one week later to discuss what she had read. As I had feared, she had lost her copy and said that she hadn't had time to read it. We met anyway and I verbally went over what I thought were the important parts of the analysis. During our visit she read the synopsis that I had written about her and she questioned the part where I said she portrays a woman "deeply embedded with the dependence mindset of the system and the powerlessness she feels towards controlling her own future". I listened to her concerns about not wanting people to think she was lazy or couldn't do anything for herself. I explained that that was not my intention when I made that statement, but that I was trying to illustrate that there are forces in society that influence us in ways that we may not always be aware of and that the welfare system was one of those. We talked about this for awhile and in her own way I think she came to an understanding of my deconstruction of her systemic influences. I did not want to put anything in the paper that would upset her or that she found to be misleading or untrue. At the same time I thought that she may not have insight into the systemic influences that she is living within. As I write this I am very aware that I am sounding like the knowledgeable academic and that somehow I understand her situation better than she does herself, which of course is untrue and very arrogant. I want to convey that I was open to feedback from the women and that I was also wanting to be true to the interpretation of the data.

*Rich Thick Description*

Rich, thick description of the participants or the setting "allows the reader to make decisions regarding transferability." (p.203) The amount of detailed description allows the reader to make a decision about whether this situation may be transferable to another situation because of shared characteristics. (Creswell, 1998) In this research project, the thick description was demonstrated in the use of direct quotations from the participants. I wanted to be able to illustrate the theme or meaning through the eyes of the participant. I feel that the use of direct quotations enables the reader to connect with the women directly and often stirs some recognition of the same situation in their experience. When my peer reviewer was reading it she made many comments about "oh, have I heard that before", or "this sounds familiar", or "I can totally relate to what this woman is saying".

Although I do not want to negate the uniqueness of each participant's life and her experience, I do feel that the themes that emerged from the interviews were best illustrated through their own words. Any further description that I may have added only helped to organize the commonalities among the women. I feel that their words were descriptive enough to enhance the perceptions of the reader and enable the truths and emotional reality for the individual participant to be better illustrated thus establishing a true connection with the reader.

## JOURNAL

In this project I established a thesis journal which I had originally thought would be academic and full of notes from insightful readings I had done. I did not really believe that it was going to be as much a part of my life as it became. If the truth be known, there would be weeks when I did nothing else for my thesis but write in my journal and to that end, not just about the academic learning that I was doing. The journal became a personal friend for me. I used it to vent, to swear, to think, to talk, to laugh and ridicule others and myself. I used to it create poetry and to verify my line of questioning and thoughts.

It would be interesting to do a qualitative study on the phenomena of academic uses of journaling. A mini theme analysis of my journal would reveal sub-themes of frustration as well as themes on the process of phenomenology. My journal's biggest purpose was that it became my *insecurity* blanket. I would often fall victim to my insecurities and doubts about the direction of the research or the intrinsic value of the research question. I would write down these doubts and then either leave them there to "rot", as I said to myself, or I would deconstruct them and find out what was the real issue. I found this a very helpful process in helping me to push through the resistance that I would feel when it came to write. If I went to my journal and read an entry that I had made it would usually spark my thinking process and I could begin to write something on paper.

In the phenomenological tradition, it is important to identify and analyze how the researcher's lens may be affecting the interpretations. As part of my audit trail, I would

use what I had written in the insecurity realm of my journal and go to the core issue. I would examine how this might be affecting my sense of the purpose of the thesis and if this was blocking me from getting meaning from the data, or if it was influencing me in a direction that wasn't real. I would write down thoughts in the margins about entries that I had made in the journal, much like doing the line by line analysis of the data transcripts, and issues would become apparent. I would then take some time to think about this issue and reflect on its influence on my writing. A major issue that resurfaced frequently was the time I was spending away from my children and the guilt I was feeling. Although this issue falls into the personal journey realm, it significantly influenced my process of both analysis and writing. At times I would begin to type anything that I could think of to try and just get something down on paper, and at one point I tried to put a different slant on an excerpt from the transcripts in order to verify what I thought I wanted to say. It was at this point that I had to stop writing altogether and think about what I was doing. Reading the journal entries over an extended period of time helped me to acknowledge my issues and allow them to be without judging myself. This in turn gave me permission to take my time in the process and reiterated the critical nature of being true to the words of the women as they were spoken and not how I wanted them to be.

I used the journal to jot down thoughts that I would sometimes get in the middle of the day or night when I was not sitting at my typewriter, but still thinking about the women. This would later help to stimulate my thoughts when the time came to actually write without having to begin at zero and feel some pressure to produce something because my opportunity was here.

I also used my journal to write down examples of times when I have encountered the use of the term culturally sensitive care in my professional world. I did this because I wanted to reaffirm to myself that there was validity in the research question that I posed. This was a very affirming process for me, because although I hear this concept a lot, when I pursued the meanings or looked at how an organization was operationalizing the concept, I was never satisfied with the result. I always felt that there were issues embedded in this statement that, unless you were knowledgeable about the systems and context of an individual you would miss the purpose of this concept completely. I was at a meeting in Vancouver listening to the co-ordinator of a street outreach project speaking about their program and saying that she strongly supported culturally sensitive care. She said that they were in the process of hiring an Aboriginal nurse, and had just jumped through all the human rights hoops to be able to advertise for this position. She stated that since most of the clientele they served were Aboriginal women she felt that adapting their service to provide culturally sensitive care was critical. They were doing this by hiring this nurse and by having traditional crafts once per week.

I came home after this meeting and wrote copiously in my journal about what I thought and what my first, second and third impressions were. I felt that the key issues about delivering the service that meets the needs of the clients were already in place through recognition of things like socioeconomics, social conditions, housing issues, addiction issues, abuse issues etc. That was the cultural sensitivity. That was the cultural milieu for those women. To hire an Aboriginal nurse because of the perception that some cultural need would be met is a potential misfit, depending on the individual nurse. This

whole process reiterated to me the clarification process that must be walked through when thinking about culturally sensitive care and the way that individual needs must be met.

Overall, the journal process has been quite a personal journey for me and in some ways has been more important because of my distance from campus and my committee. Not having the day to day contact with the academic milieu that culturally can influence my thinking process has been a definite detractor. Having the journal to restate the obvious, to tell me what I am doing wrong or doing right has been my method of discussion. Without people around me when I am available and ready to have a discussion I have to turn to my confidential friend. In reading it back now it is an interesting document in itself and I may someday consider working it into an academic project of its own.

## CHAPTER 4 RESEARCH FINDINGS

### THE PARTICIPANTS AND THEIR STORIES

#### *Josephine*

The first time I met Josephine we were in a library. I was skulking around the lobby looking for someone who might match the description she had given me over the phone. I looked up and saw a young woman striding confidently towards me. She thrust out her hand as she was introducing herself. In all honesty, I was slightly taken aback. Her confidence blinded me. As I came to know her over the course of our interview she is a woman who speaks with smiles in her words. I say this because it is with genuine warmth and human openness that she shares her viewpoints and stories

Josie is an Aboriginal woman in her mid twenties. She is a mother and a student. She is the daughter of a white father who was raised on reserve by a First Nations family and a First Nations mother who was raised in a white foster home off reserve. She says that her bicultural heritage has caused her challenges growing up.

*"I think being half you get it from both sides. Because native people, some, not all, some, have their ideas on what Indian is. It's like you have to be as dark as me, and you have to be... you know...and then on the white side it's like "well you're not as white as me." So I don't know."*

Josie grew up in a small community in British Columbia where she says their family was very poor. She dropped out of school when she was 15 to go to work. She became pregnant when she was nineteen. It was after she had her daughter that she realized , *"now I have to support this child, you know, I need to be able to support her, look after her, so to do that I can either get a minimum wage job somewhere flipping*

*burgers or I can go out and get an education and offer her all the things I didn't have".*

Josie describes herself as someone who bases her idea of herself in terms of her relationships with other people. *"I am Jody's mother, I am Theresa's sister, and I am my mother's daughter..."* she then goes on to specify that her daughter is

*"just my whole world, I mean that's the kind of...who brought me to some concept of me, you know....before I had her it was absolutely nuts! My life was crazy and unstable and I wouldn't even say I really had a life you know? It was just kind of floating through space and making little stops here and there, and she kind of made me more grounded."*

Josie was introduced to Tsewultun Health Center when she gave birth to her first child. Prior to that there had been no contact with the health center even though she knew it was there, she was never connected with it in any way. She is not a Cowichan Tribes member and so she does not concern herself with knowing about programs available to First Nations' people in the area assuming that they are restricted to Cowichan Tribes members. In her immediate postpartum period, she encountered one of the Tsewultun nurses who came out for a postpartum home visit and established a bond that holds strong today. Interestingly, she chose to come to Tsewultun for her immunization and child health conferences, each time waiting to see only that nurse with whom she had bonded, but chose the provincial public health unit for her infant development needs.

Throughout our interview, I found Josie to be very reflective and thoughtful about her answers to my questions. She is a woman like many who found herself pregnant and single and young and uneducated. She identified what she did and didn't want for herself and her daughter and took the necessary steps to help achieve that. She speaks about her feelings of being native with what I call insightful caution. She describes what she



knows to be true for her now peppered with some trepidation of what it has been in the past and what it is still evolving to be. I feel she is still becoming comfortable with herself as a bicultural woman.

**Mattie**

I had seen Mattie around the Health Center prior to our interview but had never had the opportunity to meet her on any personal level. When I picked her up for the interview, she was a little flustered and had rushed to get out of her apartment. Mattie strikes me as someone who is older than 34 years. She has a very wise face, not old or wrinkled or haggard, just mature and deep. I think it is her eyes that reach you first. They are full of stories of sorrow but somehow she manages to keep that sorrow away and behind a glaze of wonder that comes at you when you meet her

Mattie is a 34 year old woman, Cowichan Tribes member, born and raised in Duncan on the reserve. She has 6 children, the oldest of whom is 18 and who has just become a father, making Mattie a 34 year old grandmother. She has 3 sisters and 3 brothers all of whom live nearby. Mattie went to school on reserve but did not finish high school. She spent most of her time on reserve, not venturing into the town of Duncan too often. When asked about Duncan in those days, she says that she simply can't remember details about what it was like. She *"watched it grow from small to large now. We used to have alot of trees around. Alot of trees. This town really increased over the years. Watched it bloom I guess."*

Mattie got together with her first boyfriend when she was fourteen. By sixteen

she was pregnant with her first child. She says that she was

*"too young I think. I think I was a child myself having a baby. I didn't know what I was doing. (laughs) Didn't know about safe sex then. Talk to my kids about it now, 'cause I want them to do things...not that I'm saying that they're mistakes, but...but it's hard...Obviously didn't get through to my boy! Making me a grandmother already. (Laughs) Baby's due in April."*

Over the course of her life with her partner she has lived through his abuse of alcohol which led to both physical and verbal abuse towards her. He is currently trying to seriously battle his alcohol abuse and she is facing her own history of drinking to cope. She has a history of significant health problems including several surgeries and chronic conditions and most recently chronic bleeding stomach ulcers.

Despite the obvious challenges in her life, Mattie continues to forge ahead with things she deems important. She is currently enrolled in school trying to finish her high school courses. She hopes to be able to go on to some professional training after that.

Throughout our interview, Mattie would look at me beseechingly to see if she was doing okay. It was as if she wanted to please me and to give me whatever she could but didn't quite know how. It was her first time ever being interviewed and she was a little nervous throughout. The first question I asked her was to tell me about herself. Her reply was simply *"can't do that."* I proceeded to ask more specific questions about where she was born and raised etc, but I could never quite get her to reveal to me what she thought about herself in descriptive terms. Throughout the interview however, she did reveal snippets of what she thinks about herself and the life she has lived. She believes that she has changed greatly from the early days. She no longer absorbs the negativity of her late husband and says that *"for what he put me through he made me feel*

*negative thoughts like other people. Now that I've increased myself and changed myself I don't have any troubles getting to know anybody now."*

## **Penny**

I had seen Penny around the health center quite frequently in the past. I met Penny several times in health center programs or on clinic days when she and her family came for immunization. Although I had met Penny, I never got the sense that I knew her at all. In all my encounters with her, she was very business-like and rarely provided any personal information. I got the impression that she was very conscious of her boundaries and careful about what she would reveal to whom.

Penny is a very imposing woman when you first meet her. Her voice is what stays with me the most though. It is clear and resonant and quite bass in its tone. Her words are carefully chosen. She is very articulate in her own way and in my experience with her, I get the feeling that she never says anything flippantly. She challenges you if you say something that she doesn't agree with and is not afraid to speak her mind when called for. I approached Penny initially to see if she would participate in my project for this very reason. I thought that if there were to be a critique of any kind for the health center, that she would be able to find the words in her experience to give that to me.

Penny is in her mid 50's and in her words is:

*"...a grandmother, I'm a mom...ah...I'm a student , ...school, college life. I'm also a student of life...I learn from other people where changes need to be made in my own personal growth...from experience. From...mostly from other people."*

She lives with her daughter as well as her grandchildren, that she has taken on raising.

Penny is also a survivor of the residential school system that was prevalent in Canada up until the mid 70's. The residential school system was created in hopes of assimilating and integrating First Nations people into mainstream society at the expense

of their own cultural norms and ways of life. It has been described as an attempt at cultural genocide and has spawned generations of broken adults and children struggling to come to terms with who they are in this world and where they fit.

Despite the tremendous influence that the residential school experience had on Penny, she continues to struggle to find her true identity within her own Cowichan culture. She identifies learning things from Elders now that she didn't learn when she was younger. *"...my Elder he said to me, he said to the whole class, he said 'respect, care and share', so from that I draw a lot of my strength. I say our culture is built on respect, care and share."*

Today, Penny identifies herself as having learned many lessons throughout her life and relies heavily on her newly found Cowichan teachings to guide her way. She describes herself as now being *"a cultural woman. I am a Native woman. And I am a Cowichan Tribes member."*

My time with Penny was short and sweet. She was efficient in her answers and our interview came to a natural conclusion. She graciously responded to me without hint of self pity or drama, and clearly set her boundaries about topics she did not wish to discuss.

## Gina

I met Gina for the first time when she responded to the notice that I had placed on the bulletin board at the health center. My first visit was for the purpose of introduction and overview. She was very open with me in this first encounter and it interested me how she could divulge so much personal information within the first moments of meeting someone.

Gina describes herself as *"a fulltime mom, um struggling to become a working mom. And ah... a lot of struggling right now to get my kids educated....I'm married. Really happy (laughter). ah...just trying to get untangled out of the system...you know ...the welfare system."* During our initial visit there were at least a half dozen kids running in and out of the house all of different ages. I was later to learn that she has eight kids and is trying to get permission to home school them.

Gina was previously married to a Cowichan man and had her children with him. She has since divorced and remarried another man, not of the Cowichan community. As a result of this, her membership as a Cowichan Tribes member has been rescinded. Her children's father has also passed away leaving her connection to the community somewhat uncertain. She has lived several places the past few years, most recently just moving back to Duncan from the mainland. She says *"my boys, they really don't want to be away from here. I think they still...they're trying to get to know their late dad's family."*

Gina talked a lot about the challenges she has encountered with the "system". Being on welfare has both defined who she is and how she has to live. At one point she

described being in the welfare system as *"it's like you can't...I don't know...I guess it's like being in the water and not being able to reach one of those ...life tube things..."* She talked about concrete examples of how she felt the welfare system had affected her life negatively and how unfair and unjust she thought it was. Her words used to describe the situation also portrayed a woman deeply embedded within the dependence mindset of the system and the powerlessness she feels towards controlling her own future. Comments like, *"I've never been able to ...to get hooked up with anybody that will help me get off the system and take care of my kids financially. ..."*, and *"I came here with...you know...intentions of finding somebody to help me...which was my father-in-law, I said, and he moved. So there's no one. You know...it's not my fault he moved!"*, illustrate the emphasis that she places on others for her survival.

Gina told me many stories of her negative experiences within the system. As a mother, I found the most empathy with her when she was detailing her account of her housing problems. They experienced a house fire in which they lost everything. They had no insurance so were completely without the tools to live. All nine of them continued to stay in the burnt house for two months living in the one room that was still habitable. Eventually they found safer accommodations but the struggle to get there was a defining moment for Gina and her recounting of the experience incorporated a lot of the recurring issues that she has had to deal with throughout her life.



## **DATA ANALYSIS**

The following discussion will focus on the findings in the data that I gathered through the interview process. In chapter three, I discussed the process of thematic analysis whereby going over the transcribed interviews line by line reveals common clusters of meaning, sub-themes that are embodied in their described experiences. The chart below presents a summary of the overall themes and sub-themes that I derived and the order in which they will be discussed. The general themes are presented in bold type with the sub-themes clustered below in regular font.

### **IDENTITY AS AN ABORIGINAL WOMEN**

- Perceptions of Self as Expressed by Participants
- Impact of Family on Perception of Self

### **EXPERIENCE OF RACISM**

- Racism in Action
- Perceptions of Others

### **PERCEPTIONS OF CULTURE**

- Culture as defined by participants
- Respect

### **SOCIETAL SYSTEMS**

- Welfare System/Poverty
- Education

### **RELATIONSHIPS AT TSEWULTUN HEALTH CENTER**

- Relationships with Tsewultun Staff
- Negative Perceptions/ Relationship Experiences
- General Tsewultun Health Center Comments

The question that I posed at the beginning of the research process was: *"What is the lived experience of Aboriginal women who have received what is considered to be culturally sensitive care?"* As I read the data and the themes that have emerged I wonder if I have achieved my goal. I have captured some lived experience, about that I have no doubt, but whether or not it is restricted to culturally sensitive care is what I need to discuss. Suffice to say, lived experience of anyone brings to life the complicated nature of an individual's life. It is not easy to look at just one dynamic of a person's life. My experience with this project has shown me that. All that an individual brings to an interaction is shaped and influenced by what has gone on before. To talk about culturally sensitive care, the issue of culture is inextricably linked. In turn, the meaning of culture for the individual women is influenced by the impact of assimilation and colonization from a very experiential level. From here, the influences of the continuing societal forces are discussed and experiences identified that are relevant to the woman.

Some of the main clusters of meaning that I have identified may have direct relevance to the experience of the care received at Tsewultun Health Center. Others may not seem to be as directly related at first glance. It has come to be my understanding, however, that all of the clusters are very much interrelated and continue to compose the whole of the experience for the women interviewed. In my discussion, I will try to sort this out in a way that becomes clear to the reader just how influential the interrelatedness is.

## Themes and Their Meanings

I have no clear boundary between the "data analysis" and the "data interpretation". As I discuss each theme identified in the analysis, my discussion takes on the role of interpretation as well. For what is, is. My data portrays the lives of the women. I am presenting it here in a way that may help to unpack the suitcase that we all bring with us in every interaction with each other. It is my hope that I can be as truthful to their reality in my interpretations as they were in their sharing with me. Conclusions will be drawn at the end of the theme discussions to tie up and summarize.

### **THEME ONE: IDENTITY AS AN ABORIGINAL WOMAN**

In the book, the *Imaginary Indian*, by Daniel Francis, (1995), there is a passage that discusses the concept of the existence of the "Indian". He says, "Indians as we think we know them do not exist. In fact, there may well be no such thing as an Indian. ... When Christopher Columbus arrived in America there were a large number of different and distinct indigenous cultures but there were no Indians. The Indian is the invention of the European." Francis quotes Berkhofer (1979) as saying "Since the original inhabitants of the Western Hemisphere neither called themselves by a single term nor understood themselves as a collectivity, the idea and the image of the Indian must be a White conception. Native Americans were and are real, but the Indian was a White

invention..."(p. 5) He goes on to conclude, " The Indian began as a White man's mistake, and became a White man's fantasy. Through the prism of White hopes, fears and prejudices, indigenous Americans would be seen to have lost contact with reality and to have become "Indians", that is, anything non-Natives wanted them to be." (p.5)

This is a very poignant paragraph. Native people living today are struggling to clarify for themselves who they are. In the context of the previous paragraph one has to take a closer look at who dominant society thinks "Indians" are and who we, as Native people think we are. Being several generations removed from the pre-contact Indigenous people of this land, it is difficult to access real answers for ourselves when faced with this dilemma. Much of what we have learned about ourselves has come to us through our own experiences and the experience of others that has been influenced by the forces of history, racism, oppression and assimilation. These forces have tainted the images of the Indian as seen in movies, books and indeed our own families.

Who are the women I am interviewing? These are women who have grown up reflecting, deflecting and adopting a variety of images that are presented to them from others. Indians are lazy, Indians are dirty, Indians will scalp you, Indians are all drunks, Indians are peaceful nature loving people, Indians are very gentle, Indians smoke peace pipes.....and the images go on and on. It sounds hilarious when I read it on paper. But it is so true. I am certain that the women I have interviewed want to live in a world where they fit in comfortably and can go about their lives being at ease with who they are. But it is this question of identity that can plague a person. If, in fact, the very term Indian is a creation of another culture, how does that affect how these women label themselves?

Living with a label whose origins are basically meaningless and whose use was introduced by the oppressors of our culture can impact the way Native women both feel about themselves and the way the others feel and think about them.

I have accumulated data on identity in the body of this work because I think that this issue is a work in progress. There is more to be done on the relevance of culture and care and the meaning of identity in this era in which people are exposed to great pressure to assimilate into the mainstream. The discussion that ensues, then, should be taken with all this in mind and as a component of my process that I can not extricate from the central question. Self identification as an Aboriginal woman is step one in the process of coming to a health center that is designed for meeting the needs of Aboriginal people.

### ***Perceptions of Self as Expressed by the Participants***

One of the first questions I asked all of the participants was about their own perception of self.

LK: "...wondering if you can tell me a little bit about who you are?"

M: "who I am?" ( nervous laugh)

LK: "Describe yourself to me...."

M: "(laughter) can't do that..."

In this short exchange of dialogue, Mattie, the woman being interviewed, is at a complete loss of how to answer my question or to give me what she thinks I want. Her responses after this initial exchange became very one word and monosyllabic for a short time. I remember being a little stymied as to what to do now? How could anyone not really know who they are, or at least give some basic demographic information about

herself? How do I get her to talk about herself without having to lead her in my direction? As I have now come to know Mattie better, I believe that she had truly never been asked that question before and in her life had not really stopped to consciously consider it. Also, she was nervous about the interview process. Mattie was a bit edgy for the first ten minutes of the interview, partially due to the tape recorder and partly due to the role of being interviewed. In our follow up session she commented on how nervous she was in the morning prior to our appointment. She said she warmed up after she realized that I wasn't going to ask her "hard" questions and that it wasn't a test situation.

As the interview progressed, however, Mattie became more relaxed and was able to speak unencumbered. In the analysis of the data I found that although she could not articulate when asked, who she was, she gave me words and phrases about her life and experiences that helped me to get a sense of who she was. Things like *"too young when I had my first baby"*, *"I've changed now, I have increased myself"*, and *"negativity of my late husband is no longer with me"*. have shown me that Mattie is a woman who does have insight into the woman she is becoming, but may not have had a distinct opportunity or desire to create the conclusions in her own mind.

I asked Mattie,

*"describe...hmm... your nativeness? If you had to put into words, what it means to you, er..or your experience of being Cowichan or a native woman? How would you describe that? Or how do you feel about that?"*

M: *"Our culture?"*

Our conversation then turned to her ideas around the issue of culture. I was unable to get at what I think I wanted. And she was unable to articulate the meaning for

her of being an Indian woman. But maybe that is the state of being for many women. When you are in it, you can't see it. Like the proverbial forest for the trees. Mattie lives her life from day to day, without the conscious reflection in the way that I think of conscious reflection.

The other women that I interviewed all had immediate responses to this same question and (somewhat formed) opinions of who they were and what they wanted to voice on this issue. Of these three women, their initial response was to give me a list of the things they were: ie: I am a sister, mother, grandmother, student, etc. This was followed by more elaboration of each. It is interesting that the women's responses were initially a list of who they were in relation to other people. Initially, I felt somewhat annoyed that the women would immediately define themselves in terms of others and not as something of their own. I thought about this for awhile, however, and tried to consolidate what my definition of myself would be at this time in my life. I have to admit that right now I am first and foremost a mother. The power of the family on self definition is as strong a force as anything else.

Of the four women interviewed, none of them used the words Indian/Native/Aboriginal in their initial litany of who they were. They discussed this aspect of self only when solicited. One of the women, Penny, who was the most articulate and eager in her discussion of her Indianness as a Cowichan woman, was a product of the Catholic residential school. She talked about how the Church was going to *"Europeanize the native population...that was their agenda."*

Penny said that going through that system made her feel:

*"better than my people. I was better than...because I was becoming educated and because I was going to get a job and I was going to be self sufficient and all this stuff....And I would be able to talk to white people, and I would be able to ah..ah...do the things that they did..."*

Penny stated that she didn't feel like she had a native identity growing up and that she had to go to school as an adult to learn about her own culture.

*"And at the residential school, they said...they imposed upon us... the beliefs of the Catholic Church, and um...so...so my...it was all mixed up...and I'm taking ah...um...teachings from the Elders, for my class. You know I had to go to school to learn...that ...that my way was not the right way..."*

Penny is currently involved in healing herself along with others who have gone through the residential school system and have a desire to re-establish their ties with their own culture and heal wounds left from the past. Her strong sense of herself as a Cowichan woman is influenced by her journey away from it and then coming back to it as an adult.

Josephine's response to the question of identity was focused on her relationships with others, especially her daughter as she described herself as "primarily a mother." The topic of ancestry came up through our discussion of where she was raised. When asked to explain where she lived I remember her body shifting position several times and then proceeding,

*"ahmmm....I was just off reserve. A block off reserve. That's where it gets kind of complicated because ah...(cough). My mom's native. But she was taken away from her family at a very young age and she was raised in a white family. My dad is white and he moved over here from Scotland when he was ten. And he ran away from home. Well, as soon as they moved here, to the Island and he went down to Brentwood and he was raised by natives."*

It is interesting to note that for Josephine it was important to tell me prior to her



explanation that things were complicated. Later on in the interview while we were discussing how being of mixed blood affects her sense of how Aboriginal she is she says, *"It's weird but, I've always kind of acknowledged...always acknowledged my native or Indian, whichever you want to call it, it's been there and it's always been a part of me."* My guesses at this part of the interview have more to do with the feeling I was getting with Josie than the actual words. I felt her searching for her words and had a sense that she was a tiny bit uncomfortable with what she was searching for.

When non native people discuss their ancestry I wonder if they preface a statement with rationale. Or is it just the way it is? *Example: My mom was from Calgary and my dad was from France but was raised in an adoptive home.* I tend to think that things that are *issues* for us as individuals tend to be *complicated* because they confuse our minds and complicate our lives and affect our sense of our self and self worth. The phrase she used, saying "native or Indian, what ever you want to call it", make me wonder too how at ease she is with labelling herself verbally as such.

For Gina, the question of her identity focused again on family but also at great length on her entanglement with the welfare system. She spoke about her experiences with life as they related to the "system" and how that made her feel. When asked about her native ancestry she spoke about prejudice.

*" I've always put up with a lot of...prejudice. No matter where I go or how old I am. Like when I was in school, the kids ...didn't really like me alot because I ...was native...and their idea of an Indian was somebody that they saw on TV, you know? ...Riding on horses and carrying tomahawks! And killing white people!"*

Gina spoke at length about the negative experiences that she'd had regarding white

people and the welfare system. She didn't know at the time whether she was experiencing her negative responses because she was native or because she was on welfare. She also talked about having her Cowichan membership taken away when she was divorced from her first husband and how she felt about that. She did not identify anything that was positive for her in our discussion of her nativeness. Her frustration came through clearly in the interview and I believe that her identity is very much tied to this.

Of the four women I interviewed, one woman could not talk directly about her Nativeness but linked it to her definition of culture, one woman was articulate about being Cowichan and what that meant to her but gained that understanding only after going through a journey away from it and then choosing to come back, one woman had roots in both the white and native world and felt that things were complicated, and one woman was very tangled up in the systemic affects of poverty and welfare and her sense of nativeness was linked to that.

### *Impact of Family on Perception of Self*

When I was going over the data bit by bit, it appeared that there were the obvious statements about identity and how the women felt about things, and then there were the statements about all the things that formed the perceptions of self. I mentioned earlier that the main focus for the women in their explanations of self were the references to their families and the roles they played. I would like to expand a bit on this as I think that families do bring a lot to bear on the formation of who we are as Aboriginal women and as people generally. There were two basic areas that the women commented on when

talking about their families: their children and current family, and their family of origin.

Josephine commented outright how she found childbearing to be a life changing event for her. Her perspective of how she was in the world took on new meaning once she became a mother. *"She's my whole world. I mean ... who brought me to some concept of me..."* The other three women did not verbally identify childbearing as a pivotal experience for them but they all talked about their children in relation to how much they wanted them to get somewhere in life and to succeed and get an education.

The idea that you want your children to succeed in life is a common one for people no matter what their ethnic background. But often there are some embedded assumptions in this wish. Is my own life a success and by what terms? Would I want this kind of life for my children when they become adults? For the women I interviewed there was a sense that they wanted something other than their life circumstance for their children. Having children often makes you take stock of your own life and look at the values and ideas that you have incorporated into living.

Mattie identified her own early childbearing as something that she didn't necessarily want for her children.

*"...too young I think. I think I was a child myself having a baby. I didn't know what I was doing. (laughs). Didn't know about safe sex then. Talk to my kids now, 'cause I want them to do things....not that I'm saying that they're mistakes, but ...but it's hard."*

They also identified how difficult times in their life influenced their children and how they thought about parenting. Mattie spoke alot about a time in her life when her health was not good.

*"...I couldn't get up and take care of my kids. You know...my old man was drinking...and my brothers and sisters were also drinking...so I really had nobody there, so I HAD to come in for help. ...My oldest boy did all the cooking. (laughs) 11-12 years old when he started cooking 'cause I was really really sick. Couldn't do nothing. I was so light-headed..."*

Penny's experience with the Catholic church residential school influenced the way she raised her own children and then also influenced what she was going to change in the way she raised her grandchildren.

*"I raised my children in a strict manner, my daughters, and um...um...it was not very nice. So, so now I'm raising my grandchildren in a manner that I think is...is much more appropriate..."*

Having had children myself, I can agree with these women, that the things you do as an adult are reflected back to you through your children, whether it is in the manner that you raise them, or the wishes that you have for their future. In regard to your self perception, there is probably no greater mirror than your offspring.

Family of origin also exerted considerable influence over the perceptions of self and the relationships that the women continued to have throughout their life. All of the four women interviewed either made reference to having struggled with alcohol in their own life or having family members struggle with it. The impact of the instability of their families as they were growing up was clearly influential in their perception of self, whether it be related to the alcohol or poverty or lack of connection with their roots.

Mattie talked about her instability growing up. She said that she didn't get a chance to finish high school and that was mainly related to the moving that she did with her mom.

*"And we'd move out of town every now and then, you know, 'cause my Mom would leave my Dad and end up in Nanaimo. ...Never no stability. I's always have to end up going...never had a chance to make any friends. ...It was just really hard. It's tiresome. Ah. My mom went through a lot of beatings. Ah. There was a lot of fear there. You know. He'd find her...and drag her back home. And that was really hard. A lot of stumbling roads there."*

Josephine made references several time throughout her interview to the poverty she experienced growing up but could not bring herself to say exactly what it was that she was lacking that made her so embarrassed. While she was talking I recall that her face blushed profusely as she moved to a new subject.

*"...and I actually started laughing in my car by myself because ..(laughs) it was sick...I mean how did we live that way? I mean we were disgustingly poor! I mean a lot of things we didn't have... I couldn't even bring myself...like I couldn't say it now! I can't verbalize it because it's really embarrassing! I mean the core essentials to LIFE and we didn't have them..."*

Both Josephine and Penny identified their fathers as being instrumental in urging them to go further with their formal education. Josephine rarely spoke about her mother, but her father was extremely influential in her life. She mentioned several times how he was an avid reader and was "so smart".

*"...like my Dad...he's VERY smart! I mean ...he is extremely smart! I don't think he went past grade six. But, I mean, he's BRILLIANT! I mean you look at his...well, miniature library, not like a real library, but all his books he's read! ...and he knows everything! You can sit and watch Jeopardy with him and he know ALL the answers! Like going back in this century. ...and he has this thing with reading and I'm sure I got this from him. But I've always loved reading. ...just my desire to know more, from him because...I don't know...if he really, ...pushed me to do that. Like he always wanted me to read the newspaper and stuff like that. He wanted me to know about the world."*

Gina talked a lot about the struggles she's had with the system and being without any family supports. Any time she talked about problems that she was having financially

or socially, there was never any mention of a family member that helped her out. She identified gaps in her family structure both for herself and for her children.

*"...that caused a fight with my husband...so we're walking down the street arguing about you know...what are we supposed to do? And it's like, 'well you think of something,' 'No you think of something!' That caused a fight...and we were broken up for awhile and didn't know where each other was! And ahm..I ended up coming this way to ask my sister-in-law for help. And she just recently lost her brother (my ex-husband) so she's not feeling a family obligation anymore. Towards me or my kids!"*

One of the most basic of human needs is shelter and food. In the preceding excerpt Gina is out on the street and in need of a place to stay for herself and her children.

Her partner eventually leaves her, her former in-laws and blood relatives of the children have no interest in helping and she truly stands alone in this plight. It would be logical to assume that this situation would impact negatively on Gina's sense of self and her ability to provide for her children. The lack of family support has a considerable influence on Gina's life and her sense of who she is.

The reference to Daniel Francis's book (1995) on the Imaginary Indian is thus illustrated in this discussion on identity. The First Nations women identified here are all at different places in their Aboriginal cultural evolution and understanding. They have all been shaped by the forces of society, oppression, racism, and poverty, and most importantly by others of their own families and communities. What legacies of colonialism have trickled down through the generations to influence why Gina cannot get off welfare, or why Mattie has no way to articulate her sense of who she is?

In all of the previous excerpts in both sub-theme categories, the women have illustrated through their words, incidents and issues that impact on their perception of

self. One of the women was unable to describe herself in a satisfactory manner which relates to the issue of consciousness. In her book, *Iskwewak , Neither Indian Princess nor Easy Squaws*, Janice Acoose (1995) talks about her culture setting her apart from the mainstream but not being able to understand the societal and institutional ideals and structures that influenced that separation. She says,

"Not having the political consciousness or strength of spirit to challenge contemporaneous pedagogy or the school's dominating ideological influence, I shamefully accepted that I was not only different but inferior. Consequently, I learned to passively accept and internalize the easy squaw, Indian-whore, dirty Indian and drunken Indian stereotype that subsequently imprisoned me, and all Indigenous peoples, regardless of our historical, economic, cultural, spiritual, political and geographic differences." (p. 29)

This inability to see the structures that exist and to be able to define succinctly what one wants to say is brought about by the establishment's control over thought through the manipulation of one's consciousness. In order to maintain the status quo the ruling class must assert control over its citizens. (Adams, 1995) Racial stereotypes play an important role in shaping native consciousness or a lack thereof, whichever way you want to look at it. Constant bombardment with feelings of inferiority and the reality of poverty and deprivation act to shape the way one sees their world and limits how far beyond their own boundaries one can cast their understanding. (Adams, 1995)

One woman spoke a lot of the effects of the residential school, and in effect all of the women interviewed have been impacted in one way or another by either being a student in the system or by having a parent who attended. Much has been written about the government's attempts at forced assimilation. Churches and government agencies

removed children from their homes in order to break cultural and language ties. Physical abuse was doled out to students caught speaking their native languages which only added to the emotional damage individuals felt through the concerted effort to promote a sense of shame about being an Indian. (Tennant, 1990)

Another issue identified by one of the women was that of Band membership. Having the government define who you are is difficult enough to understand, but it is equally humiliating to discover that because of the death of your partner, where you once considered home is no longer so. "The imposition of labels and definitions of identity on indigenous people has been a central feature of the colonization process from the start" (Alfred, 1999, p. 84) This speaks to the issue of self determination and the question of who is Aboriginal, status, non-status, on-reserve or off-reserve. The governmental policies are not congruent with traditional philosophies that contend that membership was determined by "beliefs, and behaviour, together with blood relationship to the group. Both blood relations and cultural integrations were and are essential to being Indian." (Alfred, 1999 p. 84) This woman now legally belongs to a band where she has never resided, and has no emotional or social connections while her children are registered with the Band of their late father. Would this not influence how you think about your identity or change who you think you are?

All of these factors and others highlighted through the words of the women culminate in wanting something else for their children. The women want success as defined by the dominant society, not as defined by tenets of traditional Cowichan culture.



Their own cultural and traditional identities are not good enough. Adams (1995)

succintly states that,

"Racism can thus be seen as a cause of the development of a 'shame and inferiority complex' in regards to Indian and Metis peoples' culture. As a result the whitemans culture begins to become glorified. Due to this notion, Aboriginal peoples come to believe that the only way in which they can 'rehabilitate' themselves is through the oppressor's culture; by adopting his social values, morality and language." (p. 123)

Identity is a very complex issue and one that is at the core of this research project.

Who are these women, and what influences their sense of who they are in such a way that they identify with an Aboriginal community to the extent that they seek out a service designated for Aboriginal people? A sense of self can be difficult to find in the very best of circumstances and families but many women who live in crisis mode, ie: going from one drama to another, can have a more difficult time sorting through where the influences come from. Yet our identity is crucial to the choices we make, the friends we have and the kinds of healthcare experiences we seek out. In stating that we seek to meet the needs of our clients on a cultural level we place ourselves in the position of acknowledging that there is something unique about this cultural identity that our clients attach to. Identity is important but just how that identity is manifested must also be considered.

I thought

I thought

I uh...

I knew, I was

I uhhh,..not me

I drank alot

Because I thought

that was

the way to be

If, I was

uh,..white.

Which, uh....

I am not.

## **THEME TWO: EXPERIENCE OF RACISM**

Racism as a concept is often difficult to define and even more difficult to relate to. We hesitate to discuss it no matter what ethnic group we belong to. We either don't want to talk about something that we may be guilty of ourselves or we are ashamed of having been on the receiving end. No matter what the reason, however, it is a painful but real aspect of our society. The definition that I like to use is this:

"Racism can be defined as a doctrine that unjustifiably asserts superiority of one group over another on the basis of arbitrarily selected characteristics pertaining to appearance, intelligence or temperament...racism consists of a coherent set of beliefs (ideology) that labels, classifies, evaluates and discriminates against members of a group by virtue of their inclusion in a predefined and biologically based category." (Elliott & Fleras, 1992, p.11)

For women participating in this project, this definition means that being native unjustifiably assigns characteristics to them that they may or may not possess but that members of the dominant society may at sometime be prone to accept or assume. This comes out in many ways. What is more important, however, are the resultant feelings that the women carry in their hearts as a result of a racist action or word. It may not be easy to put into words the feelings describing an "incident of racism". It may be more of a collection of thoughts or feelings about their situation that has resulted from a lifetime of experience. As evidenced in the interviews with the participant women, the ideas that they hold about themselves as Aboriginal women are inextricably linked to their experiences of the phenomenon of racism.

In organizing the data, it was difficult to put the statements that I deemed associated with or pertaining to racism into specific sub-themes since all the stories were

different and spoke about different aspects of this phenomenon. I settled on listing the comments as they were, but breaking them into two, somewhat related, but general sub-groups: *Racism in Action* and *Perceptions of Others*. The *racism in action* subcategory has to do with statements made by the participants regarding their perceptions of an incident or the way they feel about white-native relations. The other category called *perceptions of others*, deals with what the participants think about the way others perceive them and how that may explain what an interaction may mean. Ultimately both categories are really dealing with the participant's own perceptions and both categories are intricately entwined.

### *Racism in Action*

Mattie: *"When I go up to Emergency this one nurse up there...you know...like wouldn't act. You know like I was standing there and I was really really sick. And I was throwing up blood and I was standing there and I was feeling REAL weak, it was late at night, it took her, I think, 15 minutes before she came and see me. ....I was trying to say excuse me but I was too weak.*

Lea: *"mmhmm, how was she when she actually started talking to you? Was there...was she like apologetic about ...ah...taking her time?"*

Mattie: *"No. She was all snooty. "oh what" I forget what she said "may I help you?" like a mean tone of voice, and I says "yeah, I'm sick, I'm throwing up blood". "oh really?" she says, ... "oh just go sit over there and I'll be right with you."*

Mattie was talking about an experience she had with the nurses at the hospital emergency department. It could be an experience with any two people as the main characters in this exchange. But it isn't. There is no mention of race or ethnicity, but for Mattie there was an awareness that her Indianness was a contributing factor. Based on

past experiences, her perceptions are formed around certain feelings and dynamics and with this exchange she has the feeling it has to do with race.

*Lea: "What do you think that is about?"*

*Mattie: "Mmmhm, I think the racism. That's the way I feel. Because of our culture. The color of our skin...I think..."*

It is inevitable that Mattie would come to that conclusion. If this exchange had occurred between two people who are considered to be of the dominant society with no visible, linguistic or behavioural differences, then the reason for the attitude would not be attributed to racism. Among members of the dominant society this is a privilege that goes unrecognized and is taken for granted. When you live within an oppressed group, the daily experience of your difference from the dominant society frames how you see and evaluate the world. (Elliot & Fleras, 1992)

In the dominant society, if a white person has an exchange with someone with an attitude, their own racial heritage is not questioned or evaluated. One does not have to feel bad because of who they are, correctly or incorrectly. There may be something else that they question because of the exchange, such as timeliness or their own tone of voice, but the question of their basic value as a person does not immediately become an issue.

*Josephine: " ...at the campus. Just because of the different uh, ...races that are there. Like oh, it's well...predominantly native or white people. Umm. Whatever their backgrounds are, I'm not sure. Uh. And just tensions. That come. You know that just ...come...because you have these kids coming out of high school who don't know anything about, really native people. And issues and they can just spout off and say the most horrific things YOU KNOW they've heard from their parents. And I mean sometimes there's people walking, Native people, walking out of the classes crying or...or... different things. And I mean, I'm always one to stand up and say, Hey now, keep yourself in check and think of what you're saying; and actually have some knowledge before you say it. "*

The situation that Josephine has just identified relates to the obvious and overt things that can happen which make racism real for people. It is not always so readily tangible. Usually racism is masked or justified under the guise of some other value. "I am allowed my freedom of speech..." Overt comments, or obvious "misunderstandings" do not show themselves too often in this day and age, mostly because we have driven it underground. The term "politically correct" has been thrashed into everyone's vocabulary as a kind of policing of language. Although politically correct language is more in tune with the modern understanding and liberal viewpoints of the enlightened few, it unfortunately has also become a tongue-in-cheek expression of frustration for the majority of people who are confused or apathetic about what the issue is. Although political correctness may have stopped a nation of people from using the word "squaw" in casual conversation, the meanings and thoughts that are embodied by the use of this term are still present.

This switch to the supposedly non-offensive language of political correctness is identified by Alfred (1999) as Canada's attempt to "assuage the guilt of colonialism, but in fact it is only a cover for the state's continuing abuse of indigenous peoples." (p. 83)

He goes on to say,

"The only value in the word play is for white people, who do not have to face the racism built into the structure of their supposedly enlightened country. Natives face the same conditions and suffer the same abuses, except that now the problem is less obvious because, instead of being Indians governed by the state as wards under the Indian Act, they are now recognized as 'Aboriginal' peoples with an 'inherent right' to 'self- government'. Go to a reserve, look around, and ask yourself if Indians are any better off because white society has relieved itself of its terminological burden." (p. 83)

Gina: "...they just turned their backs on us...and threatened to take my kids away if I didn't get them off the street. Everybody kept saying "well, they're supposed to help you" and they didn't! So it was...I don't know, I...just was thinking if I was a white woman...my picture would probably be in the paper with: "look at this poor woman! She's out on the street with her kids an no place to live...and can you help her?" That kind of thing was what I was thinking at the time."

The book, *Pedagogy of the Oppressed*, by Paulo Friere (1997, 20th Anniversary Edition) talks about theories of oppressed peoples and the manner in which struggle occurs. ideals which are taken on by oppressed groups and behaviors that are contrary to what is desired. At one point he says,

"the oppressed, at a certain moment of their existential experience , adopt an attitude of adhesion to the oppressor. ...Their perception of themselves as oppressed is impaired by their submersion in the reality of oppression. At this level, their perception of themselves as opposites of the oppressor does not yet signify engagement in a struggle to overcome the contradiction, the one pole aspires not to liberation but to identification with its opposite pole." (p.28)

In the excerpt from Gina above, it strikes me that there are a couple of things going on, if one were to analyze this situation with this framework in mind. As a member of an oppressed group, Gina is becoming aware of the inequities that exist in the world for her. She is aware that there is a *have* group, which is predominantly white, and a *have not* group to which she belongs. She doesn't like it. She verbalizes that to me. She does not say anything to the members of the "haves" that have contributed to the way the world is. She has adopted the way of being that oppressed groups have found themselves in. But as Friere identifies, it is not an all round equitable world that the oppressed group members necessarily want. They initially want what their oppressors have and in the same manner.

Gina illustrates her situation by comparing what may happen if she was not native

but white. She evaluates her pain against what she could have or have avoided if she was white. Not only would she be on the front page of the paper, she would be getting the help and sympathy of other white people and her situation would be fixed to help maintain the status quo.

Friere points out that the oppressor in this relationship wants to maintain the status quo and keep the power within their own group.

"The oppressor knows full well that intervention (in the reality of the power differential) would not be to his interest. What is to his interest is for the people to continue in a state of submersion, impotent in the face of oppressive reality. (p. 35)

In Friere's theoretical terms, then, it makes logical sense that the white people at the social services office would not make efforts to help Gina transform her situation. And so too, it holds that Gina wishes only to join the oppressor group, thereby becoming one of the *haves*. Adams (1995) describes this as a *colonial mentality* which is "the intellectual dimension in the (oppressed)group of emotional and psychological pathologies associated with internalized oppression." (p. 70) He says that this is just as harmful to a society as self hate is to the individual and that this mentality "blocks people from seeing beyond the conditions created by the white society to serve its own interests." (p. 70) I don't believe that Gina truly understands what is happening in terms of power and oppression on a theoretical level but she does understand it on a personal level. She knows that she doesn't have, and that others do and that she wants what they have.

There is a sense that develops over time. It arms the members of the minority group with the skill needed to know when they are in danger. I mean danger in the broad



sense. Am I going to get my feelings hurt? Are my children going to witness something that I do not know how to explain? I believe we learn this sense by repeated exposure to these incidents of inequity and racism that are hurtful and humiliating. We do not want to be exposed to this risk if we do not have to be. This sense contributes to why an individual makes the choices they make. A health center designed for a specific ethnic population helps to address this sense. In the section of the findings relating to the Health Center itself I will address this more fully, but it is important to note the link between racism and the decisions we make.

### *Perception of Others*

In this section I want to bring together some of the statements that came up in my conversations with the women I interviewed. I do not want to make this a voyeuristic experience of looking in on someone else's pain or exploitation. What I do want to do is clarify the thoughts that the women I interviewed have in their minds about what transpires on a daily basis. Although I called this section perceptions of others, I cannot really know if these statements are the actual perceptions of others. All I know to be true is that these are the perceptions that the women have based on their perceptions of the experiences with others. They have interpreted the interactions with others as revealing what the others may perceive about them. This is an important point. We make decisions based on what we believe and know to be true or false. If I thought that someone perceived me as being less worthy than they are, I might be inclined to either avoid contact with them or to set out to disprove their opinion. My choice would take into

consideration what I believed to be true about what they were thinking.

The following passages reveal a small portion of the experiences that these women have had that frame what they think about others, and what they think others feel about them.

*Gina: "I've always put up with a lot of prejudice. No matter where I go or how old I am. Like when I was in school, the kids...didn't really like me a lot because I was native...and their idea of an Indian was somebody that they saw on TV, you know?...Riding on horses and carrying tomahawks! And killing white people! And that was their perception (laughter). They thought I was kind of weird, (laughs)...I guess.*

*Gina: "The people in Chilliwack are just like...I'd say...more than half are really, really...do NOT like First Nations people, AT ALL! I don't know if you've ever been in that kind of ...you know...position where you're around somebody where YOU KNOW they don't like you! Just because...you know...you're First Nations. It's really strong there!"*

In the passage selected from Gina, she so vehemently believes that those around her who are white are prejudiced. Her experience has told her that being First Nations is something that will be ridiculed or scorned by non-natives and she has translated that into her core beliefs about the perceptions of others. This is not to say that she is wrong or right in her beliefs, but simply that these beliefs influence how she perceives the world and how she will choose to go about functioning in it.

Howard Adams (1995) discussed a study of Aboriginal communities on racism where almost three quarters responded that racism prevents them from achieving their goals.

"...The majority claimed that they were victims of employment discrimination. More than 50% stated that being discriminated and stereotyped were the worst

things about being Indian. Racism also colored reserve Indians' friendships and social activities--three quarters responded that their ability to form friendships was restricted to the confines of the reserve. Not surprisingly 80% of reserve Indians reported that they married Indians. Racism clearly circumscribes and narrows Natives experiences. It continues to be a major force of Aboriginal oppression and isolation."(p. 165)

Racism has a profound effect on our perceptions of our surroundings. Gina is living within a racist world, she frames her interactions with others with this in mind and subsequently judges outcomes in her life as being influenced by these forces.

The following are a variety of excerpts from Josephine.

*"...Like I don't have many relationships with ...white people. So I don't know how they view me. So I mean, most of my relationships are with the other native students or other students..."*

*" It's ...well, white females around twenty five, they seem to take a fascination. And it drives me nuts! Because they want to be "my friend". Only because they want to find out about Indians! You know? .....there's this one girl who just ...is ...persistent in that. And she tries to talk about issues, and it's not a friendship. But it's just like she's trying to suck all this information..."*

*"In all my classes, because there is what is called , what I call the token chapter because now every textbook I get dedicates one chapter to native issues. And ah...my crim class and the over-representation of First Nations people in prison...and actually we all had to pick one chapter out of the book to do this presentation on. And I was the only native student in the class and of course, you know, people are looking at me like... 'well I want to write on this First Nations Are you going to come in our group' and I'm like NO! I avoided it..it just seems like that's what people expect. You know? I mean I do. I know of all our issues but ...people think you should know EVERYTHING about it and specialize just in that!"*

*"That's another thing that drove me nuts, is that my friend and I were sitting in (he's a First Nations guy) we were sitting outside of the cafeteria one day up in Nanaimo and this girl comes, another Native girl and she sits beside us, and she just moved here from somewhere far away, I can't recall where, and she started talking to us. She sits down and she goes 'so are you guys in the Arts One program?' And it just REALLY BOTHERED ME! You know, I mean, I know*

*the Arts One program and I know lots of people in there, but it just seems like it's ASSUMED! Because you're First Nations that ALL you're studying are First Nations' programs or topics or...or...what not."*

*"..like she's full native and she goes, "oh Josephine. Is she that very pale thin girl? (laughter). My sister like from her tone and everything she goes; "I don't know what she was implying by that remark but she put a VERY HEAVY emphasis on PALE."*

*"So...I think, being half you get it from both sides. Because native people, some, not all, some...have their ideas on what Indian is. It's like you have to be as dark as me and you have to be...you know, and ah...and then on the white side it's like "well you're not as white as me." So I don't know.*

These passages selected from the interview I had with Josephine are full of content for analysis. What I want to make note of is the impact of perception on Josephine. In one of the selected passages, Josephine is called *pale* by another native girl. Josephine is mixed blood ancestry. Among the native community this is an *issue*. Part of the government's attempt at assimilation through colonization fits with the philosophy of "divide and conquer". Through labelling, assigning numbers and establishing a hierarchy within the Aboriginal community, the government has created an environment of mistrust, competitiveness and division. "As Aboriginals of internal colonies we have to give careful attention to tribal divisions, mechanisms and names that foster internal tribal conflict." (Adams, 1995) Adams (1995) identifies the sentiment that many Aboriginals feel on an emotional level, that of Status or treaty Indians asserting their inclination towards exclusiveness and primacy, atop the Non-status Indians, Inuit and Metis.

Josephine is asked if she is in Arts One, a program for predominantly native students. This assumption makes her crazy. She is expected to participate in the analysis

of the token Indian chapter in her classes. This too drives her crazy. It is not about not wanting to be identified as native, but it is about the narrow and limiting perceptions of others and all expectations that go along with that. These perceptions occur both within our own racial group and outside of it. Note that this struggle is verbalized by the one woman who has identified her mixed ancestry to me. She is *aware* of her position as a mixed blood native woman and sees and feels the perceptions of others in relation to this fact.

## Being Half

Being half...  
you know,  
Half of what?  
Half in  
Half out  
Half empty  
Half full  
I'm half  
Just half.

Maybe that explains  
why I'm not really angry  
I'm just sorta mad.  
I kinda fit in  
I'm almost a pass  
I'M HALF  
just half.

I want to be whole  
And maybe I am,  
but a hole of what kind in the eyes of my friends?  
One that's dug out and then quickly filled in  
by the thought of the others...  
But there's room at the top, it's not quite full up  
It's only just...

I'm half  
Just half,...only half...yes half!  
I guess that explains it all,  
....or maybe only half.

### THEME THREE: PERCEPTIONS OF CULTURE

The issue of culture is inextricably entwined with all the subtopics that I have identified in this analysis. It is a critical point in the thesis. *Culturally sensitive care....* yet the whole concept of culture eludes both me and the women I interviewed in a concrete way. I have come to believe that people have a general sense of knowing what culture is rather than being able to succinctly define it for themselves and in terms that they know as true for their lives. The following discussion incorporates two sub-themes that seemed to arise from the participants words about culture: *Culture as defined/understood by the participants, and Respect.*

#### *Culture as Defined by the Participants*

I have provided a generic definition of culture and a discussion of the topic from a theoretical perspective in my literature review. In this portion of the data analysis I have chosen to compile statements that relate to the concept of culture from the perspective of the participants and what they deem are the perspectives of those around them.

Josephine: "...But I take what works for me. And I add other things. You know. Ah, I may be part of this culture but other native cultures will also influence me.

Lee: "Uhhmm, So, and then you're talking about culture. Are you talking about things like ceremony or ritual?"

Josephine: "Yes...."

Lee: "So things like family gatherings? Or umm the way you decorate your house ..or the foods you eat. Would you consider that those have been influenced in any way by being an Aboriginal woman or that, ....do you know what I mean? Like other than the ceremony or ritual..."

Josephine: *"Umm. Well, for the surrounding things, like the uh...like furniture and nice house, its what I find attractive. (laugh) I mean. From society or from culture or...from whatever. I mean, I have some Native art and I have some whatever...contemporary art...it's just...whatever I find. And like. Okay, well that'll look good on my wall!..."*

Lee: *" Yeah. So it's just a personal choice there.*

Josephine: *Uh huh, The things it's not...I get cookbooks all the time. I like cooking. So it's not...I get Mexican cookbooks. And Chinese cookbooks. I just ah...a bit of everything....*

Lee: *Uhhh, So there's no Coast Salish family recipe that has been handed down through your mom or ..there's not really much of that? Or through your dad's family there's a dish that you see? You won't miss seeing when you're with members of your native family? Nothing like that eh?*

Josephine: *Umm. Well I mean there's certain ways that my family's prepared fish and bread and ...and whatnot. And I make that. Occasionally. If you kinda like fish. So it's like I cook fish and I'm the only one that eats fish. You know. (laughs) So that's critical. (laughs).*

In the exchange just transcribed, Josephine and myself enter into what I now call the international food discussion. I have had this experience many many times with people when trying to discuss culture. I believe that when people are uncertain of what they are trying to say, they will revert to something that they can speak about. Cultural discussions are one instance where the subject matter can be so abstract that one must return to the concrete to feel safe.

I recall attending a workshop on racism with a few nurses in which the discussion came to a place where everyone was explaining how un-racist they were and how their families had exposed them as children to all different cultures by taking them to various ethnic restaurants. I knew then that this had to be a coping mechanism of either



struggling to identify what you want to say but not knowing how or of absolving yourself of the possibility that racism might be integrated into the way you interact with others.

Josephine and I were struggling trying to come up with something about culture that made sense for us. I was as unskilled at asking the questions as she was at answering them. We reverted to food. It was concrete, we could identify specific ethnic food groups and offer them up in the discussion as filler. I ended up feeling somewhat dissatisfied with this line of questions.

Helman (in Lea, 1994) suggests that "culture is an inherited lens of shared concepts and rules of meaning whereby society's members perceive the world, guide their behavior and determine their emotional reactions in daily living."(p.307) Assuming this is true, then one's pursuit of a 'fit' with the dominant culture/society would tend to incorporate the shared rules set by that society. This 'inheritance', is typically the legacy of the colonization experienced by Aboriginal people in this country. In our struggles to find a fit, often our cultural values and rules become those of the dominant society. This occurs to the extent that a 'traditional' cultural value system or set of rules is subjugated, lost or forgotten. This is possibly a reason for the difficulty these women had in discussing cultural standards. They may no longer feel awareness or attachment to the so called 'traditional' values, or even know what they consisted of.

*Lea: If you had to put into words, what it means to you...or your experience of being Cowichan or a native woman? How would you describe that?*

*Mattie: Our culture?*

Lee: *Maybe. Yeah, is it ...yeah..talk about that maybe.*

Mattie: *I'm a strong believer in our culture...you know. I was brought up, to believe in the good Lord as well as the Creator. I believe in saving your soul....We used to travel when I lived with my late mom,...fish lakes...(pause)...and....ah, I don't know.*

I think that this exchange typically sums up the immediate responses that most people may have when faced with the direct question about culture. My question started out rather obliquely, asking Mattie to talk about herself in terms of being a Native woman. For Mattie this meant her culture specifically. But how do you describe what you live every day? I don't think that most of us could say in a nutshell what our "culture" is. For Mattie, her experience has been influenced by Christianity and colonization. She is searching for something to tell me about 'traditional culture'. She talks about fishing lakes, which she hasn't done in years but still feels compelled to offer up to me.

### *Respect*

The term respect is one that people often think of when talking about Aboriginal culture. I remember when I was in university learning about the importance that First Nations people place on the concept of respect and to "respect your Elders", and "respect Mother Earth". As I look at these oft turned phrases now, I smile to myself because I really believed at the time that they were the mainstays of the cultural beliefs of Aboriginal people...each and every one of us throughout this country.

Smirking aside, I have come to understand more about this concept through my

own personal work and through my work with First Nations communities as a nurse. Annette Browne (1995) talks about the concept of respect through the eyes of an Aboriginal community. Her findings present respect demonstrated through various caring interactions between clients and care providers. She lists six main characteristics identified as being apparent in a respectful interaction. (See p.34 of my literature review) These six characteristics are consistent with what I have come to understand as part of my role as a caregiver. Although at first glance they may seem quite generic, they are probably critical to establishing a caring relationship with most clients, and with Native clients particularly. I say this not because of the inherent value that the traditional Aboriginal cultures may have placed on respect, but because of the history of inequality and oppression that Aboriginal peoples have encountered in this country. In order to bridge the gap in services, attention must be given to the process of connecting on an individual level given the diversity of the cultural continuum in this time in our history.

In my interviews with the participants, the word respect did not surface as much as did the characteristics of respect. Each participant spoke of things that made an interaction with a caregiver comfortable or uncomfortable. These characteristics are identified more fully in part of my discussion of the Tsewultun Health Center specifically.

My interview with Penny resulted in the most use of the term respect in the context of our discussion about culture. Penny's understanding of her culture is bound by her understanding of respect. Penny has had the experience of being in the post secondary school milieu and has had the opportunity to think about the question of

culture. She has had formal instruction from an Elder and in her courses on what the Cowichan culture is about. *"...and I'm taking ah...um...teachings from the Elders, for my class. You know I had to go to school to learn...that...that my way was not the right way...and that respect, care and share is..is really important to me."*

Penny's replies to all of my questions would keep coming back to some basic teachings from her Elders. She integrated her cultural knowledge into her understanding of her world and specifically identified herself at the beginning of our interview as a "cultural woman". The following are a few of the excerpts and quotes taken from the interview with Penny:

*"Well...it is our culture to respect ourselves. **Our culture is built on respect.** And...I want to grow you to ...to respect yourself as a young person, respect yourself as a young woman and respect yourself as an Elder because you want to be teaching other people to respect..."*

*"...I remember some things my mom said to me and I talk about it. And...mostly ah...I talk about respect. Uh..my Elder he said to me, he said to the whole class, he said, respect care and share. So from that I draw alot of my strength. I...I say well, our culture is built on respect, care and share."*

*"...a conversation I had with my Elder...about two weeks ago, I saw him; we were talking about respectful ah...we were talking about being forthright. And it's not our culture to be forthright."*

*"Yes, because ah...as I said earlier...my Elder says respect care and share"if we respect other people, then I think we're culturally addressing the person."*

I find this last statement to be the most powerful of all her comments about culture. She talks about culturally addressing another person. This succinctly summarizes what I think most people would like from an interaction with others. Respect. It is simple but completely changes the nature of an interaction between two

people, depending on whether it is present or not.

In the interview with Mattie, she talked about situations and feeling that she had that were neither negative nor positive. When I asked her directly about the concept of culturally sensitive care she simply stated, *"no matter what type of person walks in the door...you just got to show them respect for...that person's needs. That's just how I feel. Cause everybody's needs are the same I think."*

### Cultural Address

What is your address?  
 I mean where do you hang?  
 Do you have a reservation?  
 Or is it just time...to barge your way in,  
 having bided your time,  
 a mere 500 years of waiting sublime,  
 for the moment of truth...on the taxpayers dime  
 just waiting to hear, ...that simple hello  
 a genuine reach for the human connection,  
 the cultural address...  
***Respect***

#### **THEME FOUR: SOCIETAL SYSTEMS**

Within every society there are those who "have" and those who "have not". In Canada, the First Nations people have come to be regarded as those who "have not", by the standards of the material western world. Without quoting statistics, I can reliably state that many of Canada's First Nations people live below the poverty line, many have minimal formal education and many are involved with our welfare system.

Of the four women that I interviewed, two were currently on social assistance and two were students at post-secondary school living on student allowances and loans. Money was identified as a major source of stress for all of them.

The theme that I have identified here I have called Societal Systems. I have also named two sub-themes within it: the Welfare System, and Education. In the interviews with the women, these themes came up as much as anything else in terms of putting context into their lives. Their lack of money or ability to get money was a major concern for all of them. They all identified wanting something better for their children than what they grew up with and for them that meant an end to poverty and living cheque to cheque.

The participants of the project did not identify all the societal systems that affect them as being instrumental in determining where they access their health care. My purpose in placing this section here is to acknowledge the issues that were revealed in the interview process that were important to the women. Poverty can and is very damaging to an individual's self esteem, especially in a society that values money, ie: the more the better. Wearing old clothes, not having transportation, having to tell your children no on a daily basis, and waiting in line ups for a three minute audience with your financial aid

worker all take their toll on an individual's sense of self.

The issues of money/welfare and education were common to all the women and came up so frequently that I felt they were integral to the true understanding of my participant's experience. For this theme I have chosen to illustrate what the women have said in order to contextualize for the reader the lives that these women live. I am coming to understand that to provide the respect or cultural sensitivity that is required and aspired to at the health center, it is probably more important to understand the circumstances and nature of the culture in transition that surrounds all of the Aboriginal people that we encounter, than to subscribe to a set of traditional values that exist within a vacuum of societal stillness.

### *The Welfare System*

The welfare system or "SA" (social assistance) as we affectionately call it, is Canada's social safety net. Although it is there for those who desperately need help, it is a structure that challenges us as a society in ways we are just beginning to recognize. Being on welfare is something to be ashamed of in this country. Recipients curse it yet count the days until it arrives. Gina's discussions about being on welfare exemplified a common experience for the welfare poor. The system is very structured and does not allow for flexibility or creativity in matters of money. Any income generated on the side by a family must be reported to the government and thereby taken off their next welfare cheque. This results in either forcing the recipient into a deceitful situation where money goes undeclared, or simply encourages the family/individual to remain dormant in their

pursuit of monetary gains. Once you are in the system it is very difficult to get out and on your own.

Underfunding of the program puts a strain on staffing. Rules are set up to minimize the amount of time clients have to contact their “workers”, thereby further alienating human relationship from the system. It is a humiliating experience to line up at the door of the human resources office for the three o’clock cattle call of allowable appointment times. The numbers of people usually stretch outside the doors of the office and women and children can be viewed standing in the rain waiting in line for their chance to see the one person who controls their financial life. This hits at an emotional level reinforcing feelings of low self esteem and worthlessness.

In her discussion on contemporary caring , Patricia Moccia (1988) says that

“our post industrial society is designed in the interests of a technical–purposive rationality rather than in the human interests. That is, social systems promote an ever more efficient domination of nature and people rather than and often at the cost of the preservation, fostering and release of their potentials. Sustained by competition and personal isolation, such a system obstructs opportunities for people to be connected to a community and for a community to fulfill its responsibilities to its members. As a result, our contemporary culture is described and defined by its alienation and fragmentation, a widening gap between the haves and the have nots and increased levels of violence against persons, nations and nature. (p31)

This widening of the gap described in the preceding passage aptly fits the situation that is created within the welfare system. Income assistance is a costly program. In the immediate realm it only costs us money. It does not generate or produce like that of big business or industry. It is not fiscally beneficial. Therefore it is kept under controlling forces with a power over structure that stigmatizes and marginalizes its



recipients in order to make it unattractive and therefore a resource of last resort.

Gina is a woman who is deeply entrenched in this system. She has eight children and could not support herself or her family with a minimum wage job, but does not have the education to qualify for anything better. She therefore depends on welfare to support her and her family. The following are excerpts from my interview with Gina.

Lee: *"So your experience of being in the welfare system, how do you think that that has affected you or can you describe to me how it ...how it makes you feel, or how it has shaped the way that you've become a woman?"*

Gina: *"I don't know. It makes me feel helpless also. You know...that I can't get anywhere! I mean..I'm...Sure I've got eight kids and I've had them, most of them are all close in age, except for a couple of them...three years apart. I've never been able to ...to get hooked up with anybody that will help me get off the system and take care of my kids financially, on my own, and..."*

Lee: *"...So you feel a bit powerless?"*

Gina: *"Yeah, it's like you can't ...I don't know. I guess its like being in the water and not being able to reach one of those life tube things. And you know they come up with ...um...first it was family allowance...now it's ah...child tax, and then they come up with a family bonus. And everybody thought they were going to be getting more money, you know. All the poor people."*

Lee: *"right."*

Gina: *"And they give you the family bonus but when you're on Welfare, they just take it all. So you don't ...you don't gain anything!"*

Gina: *"...Like the welfare system really let me down. They left me and my family out on the street in January. NO help at all!"*

Lee: *"Mhmmmm"*

Gina: *"You know. Cause the guy at the welfare office ...he didn't want nothing to do with me! When I went in there and told them that we were out on the street. I used every penny that I had to keep us off the street for almost a week. I didn't ask for my house to burn down. I didn't you know...I came here with ...you know ...intentions of finding somebody to help me...which was my father-in-law, I said,"*

*and he moved. So there's no one. You know...it's not my fault he moved"*

Gina continued to talk throughout our interview about examples of where the system had let her down. She has very definite thoughts about how she has ended up in her situation and they are related to her enmeshment with the welfare system. Her story is not uncommon. That feeling of powerlessness can be immobilizing. Gina is deeply embedded in a world where a lot of other people have a say over what decisions she makes and reinforce her belief that "she can't". She must report to the workers at the human resources office regularly. If she has questions or concerns about her SA payments she is only allowed to call between 3:00pm and 3:30 pm each afternoon. She is not involved in choosing which financial aide worker (FAW) is assigned to her "case" (ie: life) despite the fact that she must care for her family based on her relationship with her FAW. Gina is resentful and humiliated by the process and yet sees no alternative on her horizon.

Most of the women that I encounter in my job are currently on welfare. All of the women I interviewed were on welfare at one time in their life, if not now. They are all reluctant to say the word welfare. They wish for a better way of life. But for now this is their life. This is Gina's life. It is important to understand the impact of this state of being when encountering clients at the health center. Is dependency cultural? No. Is it present in the clientele that I see at Tsewultun? Yes. Is it related to the welfare system? Indeed. In this instance it is not so much the cultural sensitivity that needs to be promoted but the awareness of the structures that exist that influence and determine the

way an individual lives their life.

### ***Education***

The concept of education is inherently linked to the potential for a better lifestyle. A good education equals a good paying job. Or so we, as a society, believe anyway. Most of the women that I work with do not have a high school education. Most of the women that I work with became pregnant in their late teens, dropped out of school, had the baby, stayed home with them until the children were in school and then began to enroll in school themselves. Most of the women that I see at the health center want a better life. They say that they want to get an education. Most of them have to start with the basics like writing, spelling and math.

For Josephine, education is a way for her to care for her daughter. She sees the value in being able to get a better paying job with an education. She feels that without it she will be forced to work for minimum wage which holds no or few benefits.

*Josephine: "She's always there and she's part of everything I do. She was a part of my education...umm...like I dropped out of high school before I had her, and well OK, so now I have this child, you know, I need to be able to support her, look after her, so to do that I can either get a minimum wage job somewhere, flipping burgers, or I can go out and get an education and you know...offer her all the things I didn't have."*

Mattie's experience with dropping out of school is similar to many that I hear.

Lee: *"Where did you go to school?"*

Mattie: *"Quamichan."*

Lee: *Mhmmm*

Mattie: *"and I didn't finish school. ... and we'd move out of town every now and then, you know, 'cause my mom would leave my Dad and end up in Nanaimo. Went to school out there for awhile..."*

Lee: *"yeah. What was that like?"*

Mattie: *"uh...it was hectic. You know I really wanted to finish school. Whatever...still want to sometimes."*

Lee: "how old were you for your first baby?"

Mattie: *"I was 16 going on 17."*

Lee: *"Did you consider yourself as having been very young?"*

Mattie: *"Too young I think. I think I was a child myself having a baby. I didn't know about safe sex then. Talk to my kids about it now, 'cause I want them to do things...not that I'm saying that they're mistakes, but...but it's hard."*

Both Mattie and Josephine have the common experience of having children early and not finishing high school. Mattie, has continued having children all through her twenties and is now recently a grandmother from her oldest son (18). Mattie is still pursuing her goal of a high school equivalency but on a very intermittent basis. Josephine, on the other hand, has had no other children besides her daughter and has completed her high school diploma and is now nearing completion of a university degree.

Children and the demands of childrearing can seriously change plans and the course you will take towards getting a formal education. Not only are there demands on your time in terms of parenting, but the stressors of dividing up the energy resources that one individual has between home and school make pursuing an education very difficult. This is especially true when the woman is parenting alone and may not have the family support to help offset those demands.

Josephine, luckily, has family nearby who are all in the education mode. They help her when they can and provide motivation for her to continue. Mattie, however, has six children, five of whom are still young and dependent on her, and no real partner(s) to depend on for support. Her family, immediate and extended, continues to struggle with the impacts of alcohol abuse and is frequently in crisis.

One must question, however, why, in the first place, it is that so many of the Aboriginal women that I encounter do not have the formal education offered in our society. Are there inherent problems with Aboriginal women that make them unable to learn? Or is our education system inherently fraught with barriers to Aboriginal students?

Some Aboriginal authors argue that our education system is a powerful indoctrination tool teaching native children the importance of submitting to the establishment. (Adams, 1995) Adams goes on to say that all schools share the common goal of socializing children to the capitalist ideology and preventing counter-beliefs. This would prove very confusing to a child who is being raised in a home environment that is among the have-nots of society and ascribing to values and ideology that potentially run perpendicular to the mainstream.

Howard, then states,

“The education system reproduces and legitimizes social inequalities. Metis, Inuit and Indians have had the lowest quality of life since the Europeans arrived. Schools play a key role in passing the establishment’s ideology onto the next generation. The mental framework of one’s analytical capacity to understand the existing political system is fixed, to large extent, by the school. (p. 41)

This statement sums up the political nature of education and its impacts on students who crawl through the system. It speaks loudly about government agendas and

the fact that there are larger issues at play than simply an student's individual ability to "make it" through to grade twelve.

The other aspect of education that came out in concrete terms with Penny only, is the effects of her experience at residential school. The history and impacts of the residential school system have been widely documented and discussed on many levels in the last few years. (Adams, 1995) Issues of loss of language, self esteem, and generational bonding have been documented as well as extensive testimony around sexual and physical abuse. (Tennant, 1990) These legacies of the government's attempt at assimilation, although only spoken about here by one woman, have far reaching implications. The parents of Mattie and Gina all attended residential school as well as the maternal grandparents of Josephine. The messages that they learned there about self hatred and cultural inferiority have been effectively passed on to their children and children's children. The effects are visible in the suffering that takes many forms in this community and others around the country.

Penny makes a few statements about residential school that effectively sum up the common experience for many Aboriginal people.

*"ahmm, as a child I remember being happy with my mom and then I was removed from my home and put into a residential school. So ...so from that time on, I ...ah...felt overpowered...."*

*"they raised us in a strict manner...'you do as I tell you to do, and when I tell you to do something I expect you to say how high do you want me to jump'...the theme that seems to run through their life is ah...you can't think for yourself, until I tell you how to think. How can you learn if I don't tell you? So it's really kind of backwards."*

*"...as I got older I didn't want to go back to school. I wanted to stay at*

*home...ah...I went because I wasn't learning and I wanted to learn. I wanted to ..go to school and I wanted to get a job."*

*"...that was their point of view, right? They were going to Europeanize the native population and that was their stance. That was their agenda. They were going to wipe out the native people. And how that affected me was...I was better than my people. I was better than...because I was becoming educated and because I was going to get a job and I was going to be self-sufficient and all this stuff, you know? And I was going to be able to talk to white people..."*

For Penny, she has clearly had some time and help to try to demystify and deconstruct her experience at residential school. She understands the government agenda now, and the impacts of oppression on self and behaviors. She still struggles with this, but at least she is able to articulate the origins of her pain.

It is important to recognize the phenomena of residential school in any work that is being done with Aboriginal people. I say this as a general statement that must be factored into any discussion of Aboriginal cultural sensitivity. The culture as it exists today has gone through a food processor of sorts. The government's attempts at assimilation have resulted in changing the state of the traditional culture but not destroying it completely. Aboriginal cultures, traditions and ceremonies continued to exist, but the people living within those cultures can only carry the unadulterated forms of those cultures to the extent to which they themselves have been unadulterated. Aboriginal people have endured this imposed change and like it or not, it has affected each and every one of us to some degree. The systems and traditions that exist today are those that have gone through that food processor and have come out the other side and are now being enacted and lived by real people who are struggling to deal with the effect of this enforced change.

I have not gone into great detail or analysis with each of the two sub- themes, and it is important for me to state here that I have not exhausted discussion about them. There is more to say and much more learning to be done. For the purposes of this paper, however, I hope to draw attention to the factors that the women spoke of in their interviews. Much has been written on the social determinants of health and the influence of education and socioeconomic status on our overall health patterns and wellbeing. For my needs however, it is sufficient to identify that both welfare/poverty and education are important aspects of the participants' perceptions of their situations and are essential when considering the social and cultural context of the people you are working with.

I must reiterate that the traditional cultures of the first peoples have gone through tremendous change and economic upheaval. When working with Aboriginal people today, one is working with someone who has been undeniably shaped by the economic result of oppression and the social impact of disrupted formal education pathways.



## **THEME FIVE: RELATIONSHIPS AT TSEWULTUN HEALTH CENTER**

The last but most important theme that I want to discuss is about Tsewultun health center specifically. The other four themes have been included to provide essential context and perspective to the understanding of the lives of the women and the provision of service. This final theme will focus on the central issue of the thesis which is the perceptions of services delivered at a culturally sensitive health center.

Tsewultun Health Center's mission statement is: *Cowichan health services promotes a strong healthy community, in the spirit of co-operation, from the wisdom of our Elder's we will put into practise traditional and non-traditional ways to achieve an emotional, spiritual, mental and physical well-being.* Although this statement does not use the words **culturally sensitive**, this statement implies that some attention or emphasis will be placed on culture through the teachings of the Elders and use of traditional ways. Since this health center was developed to meet the needs of the Cowichan people it follows logically that a cultural ideology would be an underlying principle guiding the provision of services.

My question has been about how the women I interviewed perceived the health center and are their experiences here a reflection of culturally sensitive care? What is the meaning of the health center for those women?

What I have to present here are three sub-themes that came out of the interviews with the women. They relate to their experiences at the health center in very concrete terms. I have broken them down into three categories that were common to all the interviewees. They were: 1) Relationships with Tsewultun Staff, 2) Negative perceptions

and 3) General Tsewultun Comments. Out of these sub-themes I have extracted what I deem to be the daily reality of the meaning of culturally sensitive care.

In their interviews, as I have already discussed, the specific term culture was a detractor of sorts from getting at real meaning. The word itself conjures up meanings that have been predefined for us somewhere in our history and may configure our answer towards a direction other than what may be real for us. The comments gleaned from the interviews in combination with the context discussed earlier provide the essence of what the care provided by the health center means for the women I interviewed.

### *Relationships with Tsewultun Staff*

I have come to realize that a positive experience has a lot to do with the relationship that is formed between the caregiver and the client. I don't necessarily mean that a relationship must be a long term entity, with frequent interaction. What I am referring to is the actual interaction that takes place at the moment. Is there a sincere communication between two individuals, incorporating all elements of respect? The comments from the women I interviewed seem to indicate that this was important to them. In the interviews words like "real", "support", "encouragement", "personal relationship", and "take their time" indicate the importance that these women place on having a connection with the caregiver.

Josephine talked a lot about one nurse in particular who had a big impact on her life. She established a relationship with this nurse when she had her baby and continued seeing her off and on throughout the first few years of being a mother.

*"Then came the first day of school. XXX picked me up and drove me to my first day of school. There was me and my daughter and XXX sitting in the car...and I'm like...I can't. You can just bring me home now because I'm not going to either of those places! Just take me home! I'm not sure how long we sat there, it seemed like forever! We were out in that parking lot! Then "do you suppose you could come into the day care with me?" and it was "well...you know that's a door you're going to have to open by yourself." Eventually I did! I made it in that door so...so I mean...and then it's kind of all school, I mean I graduated and went on to university."*

Lee: *Did you bring your daughter here for her shots?*

Josephine: *"always with XXX, I'd sit out there and wait until I could see XXX" "I liked her! It was like we could just talk and it was like great! You know."*

*" with XXX it's always been more. I don't know, I mean she would come out with me and we'd talk, I could come here and ...like I'd never go to my doctor's office and start crying! And say god! my life is in turmoil!....it was more about everything. All the little bits. Not just the medical side or not just my daughter's side. More whole! Like she looked at everything! I mean, like spiritual and well, it also means she like, pointed out what was coming up for my daughter."*

*" ...you can go into a house as a participant or an observer. You know! and it's like she came into my house and she wasn't that aloof standoffish observer, you know like just going through the motions. You know she came and she sat!"*

Gina as well had some very distinct experiences that kept her coming back to the health center based on the relationship with one nurse.

*"...we were seeing XXX on a regular basis and she knew how upset I was that I was having to have these tests done. We had to keep going back. It was all negative you know. Up until that time we were done doing the tests, but she knew that I needed someone to go talk to ...and we got along real well, so still now when I try calling...I usually try to get her first."*

Mattie didn't specify one individual staff member or nurse but she did place an emphasis on the importance of relationship with the staff:

Lee: *"You feel comfortable when you come into the health Center?"*

Mattie: *"yeah, more comfortable than in the past...get to know everybody. I think that's the reason why I was feeling those feelings... 'cause I didn't know anybody. So then I got to know everybody and I feel a lot more comfortable."*

In all instances the women seem to be emphasizing the nature of the relationship with the staff person/individual. They discussed how they felt and what happened that made the experience a good one. In all of the examples there is some sort of emotional or psychological connection with the caregiver. The interaction is never identified as being efficient or professional. It is evident that the women were feeling respected and heard.

There is a dynamic of power that enters into any helper relationship. The nurse is the person with the health knowledge and the client is seeking it out. Benner (1984) asserts that nursing expertise is a source of power that often has transformative influence on client's lives. In this way it is not "power over" as is the traditional relationship with medicine but has gone beyond that to become a power that enables others. This kind of power is based on respect of others, requiring their active and equal participation.

Peggy Chinn in her book, *Peace and Power, Creating Community for the Future*, (1995) also talks about the impact of power structures on relationships and how differing approaches to the use of power can influence outcome. She says that by valuing the personal power of each individual and utilizing consensus in decision making with the client, each person's perspective is heard and considered. This enabling power is based on respect for the diversity among people, rather than an expectation of conformity.

For the clients who come to Tsewultun, there is a connection based on the positive experience they have encountered in the past. The nurses and staff they have

encountered have related in a way that is meaningful for their lives. This doesn't happen by accident. This demonstrates the skill and inherent understanding that these staff members have in working with Aboriginal people. There is a knowledge of the power structures that exist in society, the need to include the individual rather than exclude, the necessity to be heard and the basic human need for respect

### *Negative Perceptions*

I do not want to spend too much time documenting the negative experiences that the women have identified. I feel that I have already mentioned this aspect in the sub-theme on racism. What I would like to do here is list some of the statements that were made in relation to health services both at Tsewultun and other health agencies that contribute to the general overall sense of dissatisfaction with the provision of services at either the health center or other agencies. I have included examples of negative experiences from outside agencies here to illustrate situations that are contrary to the desired outcome. It was also much easier for the women to describe situations that were negative for them and in which they felt uncomfortable than it was to discuss what they liked about Tsewultun. Often a positive comment about Tsewultun would follow a negative experience story.

*Josephine: "...all these different people knocking on my door saying...and picking at my child and ...and she wasn't a baby you know? ...and these people came in and they picked at her like she was a...a specimen...you know? And that ...drove me nuts!"*

*"...Pediatricians! ...it drives me nuts! I mean I could rip my hair out! You know it's just...and now it's only every six months. But before it was every three weeks*

*I had to go see him...and it was very condescending! His attitude was very condescending! Ahh...'and what are YOU doing now? And yes...you've been a very good mother haven't you...and how many pills a day have you been giving her?' ....I mean it's just the attitude!"*

*"...like the other people, they weren't in my home, they were at their job! You know? ...it felt like they were ...something or someone different than me, you know? It's like...you know...they were so far away! And they were in my house! But they were still far away."*

*Mattie: "...when I first went here I felt negative feelings. I don't know because it's probably my first time walking here...I felt very uncomfortable."*

*"...well, I've been through alot in the past...a lot of abuse...and more or less...fear...and well I guess you could more or less say...more or less fear of what they know what I was going through...I mean...behind closed doors at home..."*

*"I don't know. It was more or less fear I guess...that's the reason I didn't want to come by you know...crazy thoughts went through my head I guess. You know ...people would talk...wondering why you're going there. Like you know, assuming there's something wrong with you all the time."*

*Penny: "...I was talking, and talking and talking...and then finally she asked me, you know, who was this, and I says...'well this is Penny', and she says, 'oh Penny! I thought you were one of those other people' and I think that's exactly what she said, too, but ...but the tone wasn't the way I portrayed it but the words stuck with me. And...and I wondered...'well, what does she think of other people?' ...I wondered if...she thought...that...the Cowichan Nations was not able to ...to ...to ask for help if they needed it. That was...ah..a question."*

In all of the above excerpts there is an interpretation of the event that leads to a negative feeling. The women identify frustration, fear, confusion and an overall dissatisfaction with the situation. Josephine talks about feeling distanced, patronized and enduring an attitude problem with health care workers. Mattie talks about her fears of what she might encounter with other people. She fears the possibility of gossip, breach of confidentiality and judgement by others. This indicates a lack of trust in the workers she

is about to encounter which translates to personal safety concerns. Penny talks about an incident where she got the feeling that the person she was talking to had some biases or prejudices about the Cowichan Nation. She is unsure but has definite negative feelings and questions about the encounter identified.

In all of these encounters, the dissatisfaction is about the connection or lack of connection with the individual in a way that feels right, ie: without fear of judgement, attitude or prejudice. The perceptions may or may not reflect the intent of the person they interacted with, but the perception is valid regardless. It is the way these women felt in those situations. It is not likely that the intent of the caregiver was to result in a negative experience, but that was the outcome. In the moment when a caregiving transaction occurs, does it contain the substance necessary to meet all the needs of the client in a wholistic way, be it cultural or otherwise? Or will the memories of that transaction be one of frustration because of what is perceived as a negative attitude is the dominant characteristic exhibited by the caregiver?

In A. Browne's (1995) article on respect she identifies contrary cases that help to elucidate what is regarded as disrespectful interaction between client and caregiver. She identifies "lack of respect stemming from discriminatory attitudes", (p.104) similar to what both Josephine and Penny are talking about in their case. Mattie's comments confirm another of Browne's contrary characteristics in her fears of gossip. Browne states that "failure to provide privacy for patients" conveyed a sense of disrespect for the patient's modesty. (p. 104).

The following two sub-themes continue from this one. The perceptions of the

women regarding nurses, other Tsewultun staff and Tsewultun programs are very much related to the feelings that they get when interacting with them.

### ***General Tsewultun Comments***

In this last section I wanted to conclude by adding some of the general comments that the interviewees made about Tsewultun that did not fit into any other sub-theme category specifically. There is nothing in this section that is distinctly different from the other categories but I felt it is a good summary of their experiences of Tsewultun as a whole.

Penny, who I have personally identified as being careful with words and thoughtful in her judgements, had this to say about the health center:

*"Generally speaking...my experience from this office has been on the level...it's been great. I have felt supported. I think it's important that people are ...when a person come here...they're being ....is acknowledged and this is a... caring place. The people should be showing...caring...."*

I asked Penny what her thoughts were on the subject of hiring native people to provide care to a native population. Her response was most interesting and gave me a lot to think about.

*Penny: "I think native people ought to be hired more in administration. And I think more native people should go and get their education. ...So I think I would like to see a lot of native people going back to school and getting the jobs that are, you know... that should be theirs."*

*Lee: "Do you think that it makes a difference to have a native practitioner or a non native practitioner? Does it make you feel differently?"*

*Penny: "Well...uhmm, I feel ....I can't...well...I'm not sure. I feel like I want to say that um...like I said native people should be there and ...and the people that*



*are non native...that are here...and that I've talked with...and at great deal and sometimes intensely...are still respectful and it doesn't matter. Any person can be respectful...but in their own way...I think that the way I respect a person is by listening and by having some kind of interactions with them. ...But I think that when reaching out and this is what this place is and does...it reaches out to our community...that that people should address other people in a respectful manner.*

Mattie was more concrete in her praise of the health center when asked what her thoughts were. She said: *"When I finally realized I needed someone's help that's when I came by here. And this is the only place where I could count on for help...and they act immediately and don't take their time..."*

When I asked Mattie about the native and non-native nurse issue she stated:

*"...It don't matter to me anymore. In the past it did. You know, like I'd say 'what's that white person doing here? She shouldn't be there!' and probably because that the way I used to hear my late husband talk. ...I've changed and it don't matter to me anymore. Just as long as she's qualified and able to do things like...what we need....cause they're human as we are. ...no matter what type of person walks in the door...you just got to show them respect for...that person's needs. That's just how I feel. Cause everybody's needs are the same I think."*

Josephine was gushing when I asked her to talk about her experiences at the health center: *"Now this is going to be really amazing! Because I've had nothing but...I mean everything here has been so good!"* Although her experiences at the health center have been confined to the services of one nurse in particular she felt that it reflected a good place overall.

Gina spoke alot about her experiences with social services and a time when her children were placed into a foster home. Although that time specifically was difficult Gina spoke highly of the service she received at the health center.

*"..The people here treated me really good. I mean, they were real supportive, and you know like I've said, were trying to help me get the counselling going and the ...big buddy thing for the boys...the girls were going to see an art therapist on a regular basis. But once my son got in that foster home it was just at a dead stop...we were getting more help from here (Tsewultun) than him being in a foster home."*

When I asked Gina whether receiving services from a non-native compared to a native practitioner made any difference to her, she said simply: *"not usually. I don't think so."* I was a bit surprised by her response because she was the woman most vocal about her views on racism and prejudice and the treatment that she had received from non-native people in the welfare system.

I have thought a lot about this particular issue of racial or ethnic fit. Based on what I see at the health center I cannot provide blanket support for the premise that Aboriginal people are best suited to work in Aboriginal communities. My feelings are that ethnicity is important only insofar as there may be a shared experience or common understanding. An "insider's view" can function as a way of knowing as effectively as a learned deconstruction of societal systems but only if the insider agrees to acknowledge those experiences as valid. By this I mean that if I, as an Aboriginal nurse, refuse to acknowledge my heritage, my experience with racism and the impacts of colonization as testaments to the reality for Aboriginal people in Canada, then I am likely not a suitable candidate for working in the Aboriginal community. If I view my experience with these things as real and valid and part of who I am, then this shared experience will provide me with insight into the influences that exist in the lives of the people I serve.

## CHAPTER 5 SUMMARY OF FINDINGS

I think that in establishing the term "culturally sensitive care", or developing programs that are aimed at specific target populations, we have created a situation where care givers are called upon to assess more than just their clients' physical-emotional state of wellbeing. I questioned myself earlier about how we as nurses/ caregivers go about addressing the history that each client arrives at our door with. What aspect of the individual do we focus on and what assumptions can we make? I am unable to fully answer all my questions through my exploration here but I will hopefully bring to light the importance of discussing this topic and the realization that there are many things embedded within the client that may not be assumed. At this stage in our country's and society's history we cannot make any assumptions about any of our clients regardless of ethnicity or culture. I think that it is crucial that we as health care providers enter into explorations of the context and milieu of those clients that we find ourselves serving.

In this study, I interviewed four Cowichan women from a variety of experiences and backgrounds. It became evident early on that I was not going to get a defined pat response to my own mental queries about culturally sensitive care and in fact only unearthed more questions for myself as I went along. What I did find however is that there is a very important place for context in the formation of a client - caregiver relationship. This phenomenological examination of the individuals and their perceptions of their experience with the health center revealed the five themes that I identified earlier: **Identity, racism, culture, society and relationships with staff.**

The issue of identity was important for me to explore because of the specific

nature of providing culturally sensitive care. One's culture is embedded in how one chooses to identify themselves. A health center for Aboriginal people implies that people who identify themselves as Aboriginal would access services there. What I found was that there is a variety of ways in which these four Aboriginal women choose to identify and perceive themselves. Their identity is influenced by the forces of colonialism, oppression, religion, family and community. Aboriginal people are not all the same. This is critical to acknowledge in preparing oneself to address the health needs of Aboriginal clients in a culturally sensitive way.

Racism was another major theme that emerged from the study. The hurts from past incidents of racism were evident in the interviews as were the impacts that racism has on a caregiver-client relationship. The women identified that they were very aware of racism existing around them and it had an impact on their sense of personal safety. They perceived that others in the larger community held racist views and this perception influenced how they conducted themselves or how they would make their choices. A health center that acknowledges the phenomenon of racism and strives to repair this inequity would logically be more appealing to someone who has endured racist environments. In recognizing that the negative experience of racism has affected these four Aboriginal women, any goal of providing concrete culturally sensitive care should aspire to eliminate this barrier at the very least. It was the women's belief that Tsewultun Health Center was not a racist place generally although there was one incident where one woman was unsure of her analysis of an encounter and felt that a staff member could have been holding somewhat prejudiced views.

The concept of culture was explored in order to unearth some of the tacit information embedded in the term culturally sensitive care. What exactly is our understanding of culture and what is the women's understanding of culture? Generally speaking this discussion was unsatisfactory and yielded little concrete information about the perceptions of culture specifically. It did though tell me a lot about the abstract nature of culture and emphasized the difficulty in defining this concept. All the women identified their culture in some way that related to being an Aboriginal woman, but most had a very difficult time in being specific. We moved from the topic to related aspects of behavior and then eventually discussed food.

The abstract nature of exploring this concept speaks loudly to the need to carefully consider what it is you are trying to achieve when attempting to provide culturally sensitive care. Is it truly for the cultural specificity of Aboriginal people? Or is it to meet the needs of an oppressed people that have experienced a variety of influences that render their situation disadvantaged?

Societal systems is addressed through a discussion of this latter question. The women I interviewed all identified many social and structural barriers that they perceived as influencing their lives. Their lack of education, their poverty or entanglement with the welfare system, the influence of the residential school system and its legacies all emerged as common issues within the lives of the participants. A sense of shame existed when talking about the poverty endured or the perceived powerlessness of being on welfare. These barriers hinder full participation in our society by any disadvantaged individual and result in perpetuating the segregation of a specific cultural group. These barriers were

also the influences that most affected the daily lives of the women I interviewed. Basic needs like money and shelter were a greater priority than examining cultural beliefs. The culture of daily living is significant in this discussion and that culture is framed by societal influences.

The last theme highlighted the comments made when discussing Tsewultun Health Center directly. The women identified contrary situations where they experienced discomfort when accessing health services in the larger community as well as at the health center. These negative experiences were mostly around attitude of the caregiver, or the perception of a disconnection between caregiver and client. Words like, "condescending", "treat like a specimen", and "felt far away" all relate to the perceptions of the relationship dynamics occurring between the client and the caregiver at the moment of interaction.

The positive comments about the staff/and individual nurses were also about the relationship they perceived to have at the moment of interaction. Words like "feeling respected/supported", "she came and sat", "someone to talk to", and "got to know everyone", were indicative of the overall satisfaction with the service at the health center. Generally speaking, none of the women interviewed felt it was critically important for the nurses providing care to be of Aboriginal ancestry. One woman felt that she would like to agree with that premise in principle but on reflection felt that respect was still the overriding factor in providing good care.

The lasting impressions for the women I interviewed were all about feeling respected by the caregiver and knowing that they would be safe at Tsewultun. Being able

to feel heard without having to explain or apologize for being Aboriginal was important. Knowing that they would not have to experience a racist comment or attitude based on their ethnicity was a relief. For the women I interviewed, Tsewultun was a good place to come to for help and to be listened to honestly and openly and with respect.

In my introduction of the thesis, I spoke about an assimilation continuum. The first four themes are connected directly to my usage and understanding of this term. The discussion about identity and the attachment one feels towards being labelled an Aboriginal person illustrates the complex nature of the self. Experiencing racism throughout a lifetime can impact the desire or choice of an individual as to whether or not they label oneself in such a way as to draw further criticism from the offending society. If in fact, ones' cultural ties are deemed to be responsible for discomfort and painful memories does that impact the continuation of those "traditional" beliefs/behaviors/values? Are there tendencies to grab hold of what the dominant society deems as appropriate in order to rid oneself of the stigma of being a less accomplished individual. By the same token, are there individuals who hold on to the teachings and values of the traditional societies in order to combat those very same feelings/experiences, but in a way that keeps them closer to their roots? These questions illustrate my inquiry and exploration of that term. Do we as Aboriginal people exist in flux and fluidity, moving unconsciously and consciously on a scale of assimilation with the dominant society? Could we each chart a graph showing our movement on that cultural continuum throughout our lives depending on the way we emotionally and psychologically interpreted the influences on our lives? Do two individuals who may be

on different locations on that chart or continuum then warrant different care culturally speaking?

### *Implications for Nursing*

In summary, I will refer back to a question that I posed in my exploration of the literature in Chapter 2. There I stated, "given that Aboriginal culture is no longer intact in its purist form and given that its existence has been altered and influenced by the forces discussed, we must ask if there is still a place in which to consider culture in the process of caring for Aboriginal people." (p. 27) What is the nature of culturally sensitive care? If a caregiver subscribes only to a set of static characteristics that have been written in an academic journal to illustrate what Aboriginal culture in Canada looks like, then indeed there is no place for culture in this caregiving transaction. If a caregiver understands and acknowledges the forces of colonization and oppression that have irrevocably influenced the Aboriginal peoples in North America, and understands that Aboriginal people have undergone tremendous change and transition and do not exist in a vacuum, then there is a place for cultural clarification/sensitivity in a caregiving transaction. Recognizing the existence of a so called assimilation continuum as a way of initiating an understanding of the influences on culture is an important jumping off point.

According to the experiences of these four women, culturally sensitive care incorporates an understanding of the forces that shape identity and an individual's choice to express that, the meaning of real racism and its impact on the individual experience, the nature of culture and the difference between a culture of daily living and the



ceremonial or cultural rituals that may or may not be present in an individual's life and the impact of societal pressures. I have concluded that the important part of providing care to these Aboriginal women includes an overriding and sincere effort to understand the context from which these women originate. It is critical that recognition be given to the broad historical factors that have influenced the individual's life and personal development, as well as the structural and societal influences and barriers that frame their current existence. Respect as an underlying principle, although undefined in this study, is held in high esteem by the women. Connection on a deeper level where trust can be developed with the caregiver is also decisive in determining what a positive interaction is.

Although I have explored a broad range of subject matter in this paper, there is still much work to be done. I have identified several influences on the caring interaction but more needs to be done on the extent of that influence. Continuation in defining the meaning of culture for Aboriginal women is an important link to further cultural program development as is the issue of identity and its impact on health seeking behaviors. It is in the best interests of both our clients and our professional body of nurses to pursue this area of study for improved competency in cultural relations with Aboriginal communities.

## Culturally Sensitive

Ouch! that hurts  
I'm sensitive there.  
don't touch me too hard,  
or give me a stare.

Is it politically correct  
to look me right in the eye?  
Or nod conspiratorially as another Indian walks by?

I just cannot pretend  
To know what this all means  
Is it helpful or hateful or caught in between,  
the belief that we warriors just run with the wind,  
and carry our battles in bottles of gin, or of whiskey, or sin, or whatever  
the church does decry?

The past is the past, and what's gone on has left  
it's mark on our genes  
to the emotional bereft  
of our young who stir restless  
in breathless await  
for the human revolution that will  
free them of hate and of bondage of labels  
so succinctly applied.

So please greet me and treat me  
as one of the race,  
in the culture of all but acknowledging my place  
and the history that's behind me  
and the future that's before me  
and be culturally sensitive,  
but please,...to my face!

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Appendix A: Research Notice

**A RESEARCH STUDY:**

**CULTURALLY SENSITIVE CARE  
WHAT DOES IT MEAN FOR YOU?**

THE GOAL OF THE RESEARCH IS TO UNDERSTAND WHAT IS THE **TRUE AND LIVING EXPERIENCE OF ABORIGINAL WOMEN** WHO SEEK HEALTH CARE SERVICES FROM AGENCIES THAT HAVE BEEN DESIGNED SPECIFICALLY TO MEET THE NEEDS OF ABORIGINAL PEOPLE.

WOULD YOU BE WILLING TO SHARE YOUR EXPERIENCE?

I WOULD BE VERY INTERESTED IN TALKING WITH YOU. I WILL BE INTERVIEWING WOMEN FOR AT LEAST 3 ONE HOUR SESSIONS. INTERVIEWS WILL BE AT LEAST A WEEK APART AND AT TIMES CONVENIENT FOR THE PARTICIPANT.

MY NAME IS LEANNE KELLY. YOU CAN REACH ME AT TSEWULTUN HEALTH CENTER 746-6184 OR AT MY HOME IN LADYSMITH 245-8311.

ALL INTERVIEW WILL BE CONFIDENTIAL AND YOU MAY WITHDRAW FROM THE STUDY AT ANY TIME. I LOOK FORWARD TO HEARING FROM YOU.

THANK YOU FOR YOUR INTEREST



## Appendix B: Letter of Consent

I hereby give consent for my participation in the study entitled: Culturally sensitive care:

### What does it mean for you?

I understand that the person responsible for this study is Leanne Kelly, graduate student at the University of Victoria. (telephone number 746-6184 or 245-8311) I understand that her faculty supervisor is Anita Molzahn, Dean of the Faculty of Human and Social Development. (telephone number 721-8050)

Leanne Kelly has explained to me that this study has the following objective: to understand how aboriginal women are experiencing the health care services that have been designed and targeted specifically for the aboriginal population. It is hoped that the findings of the study will develop knowledge and understanding of the true living experience of actual women. This information will be for health care workers seeking to provide better care for aboriginal individuals

Leanne Kelly has explained to me that I will be interviewed at least three times and that all interviews will be taped. She has also explained to me how my information will remain confidential. All interviews will be tape recorded and tapes coded by number. They will be held in a locked cabinet until the data analysis is complete, not for a period to exceed three years at which point they will be destroyed. All written recording and transcripts will be kept in a locked cabinet and kept for seven years after completion of the project. Fictitious names will be used in the transcribed text and in discussions between Leanne and her supervisor. Only the researcher and supervisor will have access to the tapes.

I am also aware that although every effort will be made to maintain confidentiality Leanne

Kelly has explained to me several situations where that confidentiality will be broken. They are: If I disclose situations that indicate current suicidal tendencies, recent incidents of child abuse, severe depression requiring immediate attention, or illegal activity which may result in injury to myself or others.

My participation is totally voluntary. I can withdraw at any time, without explanation and in doing so I know that any further care or services that I may receive from the health center will not be affected in any way and I will not experience negative consequences of any kind. If I choose to withdraw I can take my interview data collected up to that point, with me. I have the right to refuse to answer any of the questions I do not wish to answer. If I have any question about the study I can ask either Leanne Kelly either in person or by phone (245-8311 or 746-6184) or her supervisor Anita Molzahn (721-8050)

My signature indicates that I am willing to participate having read the above

SIGNATURE

DATE

### Appendix C: Interview Questions

1. Tell me about who you are?
2. Can you tell me about who you are as an aboriginal woman?
3. Tell me about your culture.
4. How do you feel about being Aboriginal in the world as it is today? (as opposed to what we think we know about a hundred years ago)
5. How do you feel about yourself?
6. How do you feel about your health? (spiritual, emotional, mental,)
7. Tell me what you do when you want to seek some health care services.
8. How easy/difficult is it for you to get what you need? (health wise)
9. Have you ever had a memorable experience when you have gone to seek out health care, either positive or negative?
10. What was it about the experience that made it that way?
11. Have you ever gone to Tsewultun Health center or to the Friendship Center for services for anything?
12. Tell me about your decision to go there. Why go there?
13. How is the service that you get there any different for you than anywhere else that you may have been? Or is it the same?
14. How important is it for you to feel comfortable when seeking services? Tell me about what comfort means for you.
15. How important is it for you that your aboriginal roots be acknowledged?
16. Tell me about your experience of interacting with the workers at Tsewultun or the Friendship center.
17. Do you think culture is an important part of your visits with the Tsewultun/Friendship center staff?
18. Have you ever experienced a time when you felt your culture was being ignored or perceived

in a negative way? (at any health agency)