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University of Washington PH.D. 1985

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AN ETHNOGRAPHIC STUDY OF CHILDBEARING PRACTICES AMONG A COAST SALISH BAND OF INDIANS IN BRITISH COLUMBIA

by

HEATHER FRANCES CLARKE

A dissertation submitted in partial fulfillment
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

UNIVERSITY OF WASHINGTON

1985

Approved by: Nancy Rhode
(Chairperson of Supervisory Committee)

Program Authorized
to Offer Degree: NURSING

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Abstract

AN ETHNOGRAPHIC STUDY OF CHILDBEARING PRACTICES AMONG A COAST SALISH BAND OF INDIANS IN BRITISH COLUMBIA

by Heather Frances Clarke

Chairperson of the Supervisory Committee:
Professor Nancy Fugate Woods
School of Nursing

The general purpose of this ethnographic study was to provide a descriptive analysis of childbearing practices among a Coast Salish band of Native peoples. A specific purpose was to discover the Coast Salish perspective of drinking behaviours within the context of childbearing practices and related sociocultural experiences. The study considered the importance of this sociocultural environment by identifying both traditional and contemporary childbearing beliefs, values and practices of Native women. The relationships between transactional processes and childbearing beliefs and practices were explored.

The research method used was ethnographic, requiring that both emic and etic approaches to data gathering be employed and that research be primarily conducted in the natural setting. Rather than imposing upon the Native peoples theory and hypotheses defined by the investigator, the study took the grounded theory approach. Data elicited

from the peoples themselves and from their traditional way of life were used to give a dynamic quality to the research process.

The conceptual framework for the study was synthesized from both Native and nursing perspectives. The Native Medicine Wheel philosophy provided the basic concepts for the structure, while a nursing perspective to woman-environment fit and transactions added process concepts. This was supplemented by a literature review of Native health and childbearing experiences, families as environments and transactional processes of education, ethnic identification and development of a self-concept.

The elicited childbearing beliefs, values and teachings, categorized according to the four directions of the Medicine Wheel, coincide with the four elements of holistic health: physical, emotional, sociocultural and spiritual. The transactional concepts were developed from data that described processes occurring between the woman and Band.

The findings indicate that the transmission of childbearing beliefs, values and practices from one generation to the next, and within generations, is of significant importance to this group. However, dilemmas resulted when women were faced with incomplete transmission of traditional teachings and/or differing contemporary advice. Continua of commitment to traditional teachings about nutrition, activity, emotional state and labour behaviour were developed. Those related to the emotional state had the highest degree of commitment; while a desire was expressed to increase commitment to activity teachings by women considering future pregnancies.

The findings have implications for nursing and other health care professionals working with people of different ethnic backgrounds. A number of questions for further study were recommended. They addressed the need to identify traditional/contemporary issues, resolve dilemmas the Native women face, provide culturally/sensitive healthcare and develop nursing theory.

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CHAPTER 1

INTRODUCTION

The health status of Canadian and British Columbian Native peoples appears bleak, and almost inexcusable when one considers the democratic philosophy and wealth of the country. The tenets of the Canada Health Act (1984) seem to be applicable to particular segments of the population, leaving many minority groups to feel they are fending for themselves. Jake Epp, Minister of Health and Welfare Canada, clearly, summarized the commitment to preserve the present health care system: its universal accessibility, comprehensiveness, and accountability (Allen, 1985). He also stated that according to recent polls the public considers the health care professionals the group best able to preserve the health care system: better than the provincial and federal governments.

Many unhealthy or adverse fetal and maternal outcomes of conception are preventable, or at least reducible. Although chosen at-risk lifestyle behaviors are most frequently associated with adverse outcomes, significant contributions are made by the individual's environment, biological characteristics and health care delivery system (Lalonde, 1974). A New Perspective on the Health of Canadians addresses these issues by stating

> It is evident ... that further improvements in the environment, reductions in self-imposed risks, and a greater knowledge of human biology are necessary if more Canadians are to live a full, happy, long and illness-free life... and

> that...the Health Care System... is only one of the many ways of maintaining and improving health. (Lalonde, 1974:1-2)

In British Columbia, the Native Canadian Peoples experience an unwarranted number of adverse pregnancy and infant outcomes, have the poorest level of health and experience discrimination problems within the existing health services (Report of the Community Health Centre Project, 1972). It was a concern about the incidence of Fetal Alcohol Syndrome (FAS) among Canadian Native peoples that led the investigator into this study.

> Although no cases of fetal alcohol syndrome were reported as such in 1982, we (Health and Welfare, Medical Services for the Pacific Region) consider that this does not represent the true picture and attribute this lack of data to reluctance to report this condition. (Health and Welfare, 1982 :17).

Other sources of reports and studies have noted an increased incidence of children with F.A.S., with a disproportionate number born to Native women (Asante, 1981; Smith, 1981; Macleod, 1983). The lack of reporting may reflect a counter-reaction to both the widely held drunken Indian stereotype and an expectation that a greater number of cases of F.A.S. would be discovered among Native peoples than the general population. Leland suggests that,

> There is no doubt that reports of high incidence of alcohol-induced birth defects among Indians, however accurate, reinforce the already pervasive Firewater Myth among both whites and Indians, and hence help to assure that continuing self-fulfillment prophecy (Leland, 1978:112).

Nonetheless Native peoples are concerned about both their children's health as well as their own health and alcohol use.

However drinking is only one of many lifestyle factors affecting health and occurring within varying contexts. Therefore, the focus of this study was to investigate general childbearing factors, including alcohol consumption within the Native peoples' cultural context. The purpose was to gain a better understanding of childbearing beliefs, values and practices in order to generate questions and hypotheses dealing with health promotion and primary prevention.

The Health Field Concept

A previous study on the conditions of Native Indian children and their families demonstrated the importance of considering each of the Health Field Concept elements when determining the need for early childhood programs for Native children from birth to 5 years of age (Ramirez & Walker, 1980). The major concerns identified were: 1) inadequate prenatal care of mothers; 2) nutritional deficiencies; 3) unavailability of adequate health care for children; 4) lack of consistence, nurturance and stimulation due to such factors as unemployment, alcoholism, transitional status of Indian cultures; 5) culture and language differences: and 6) unfamiliarity with existing services. Similar studies have not been done in determining the needs for childbearing programs for Natives. Nonetheless it is reasonable to assume that the holistic perspective required for child-

rearing is appropriate to other stages of the lifecycle such as childbearing. Adverse pregnancy outcomes, including the Fetal Alcohol Syndrome (FAS), are just as likely to occur as a result of the interaction of the elements of the Health Field Concept: i.e. lifestyle, environment, human biology and health care delivery system (Aase, 1981).

Lifestyle

Lifestyle factors consist of decisions individuals make that affect their health and over which they more or less have control (Lalonde, 1974). The results of these decisions are frequently reflected in the level of health attained by the individual or group. Morbidity and mortality rates are associated, in part, with chosen lifestyles.

The Coast Salish Natives of British Columbia have traditionally spent much time and activity in promoting wellness and preventing and curing illness (Amoss, 1972). At particular stages in their life cycle, both males and females were required to adhere to and practice "disciplines", or rituals, to increase their strength and health: bathing in cold water, isolating oneself from the rest of the band, rising early and keeping busy with appropriate responsibilities. Puberty was a time demanding strict adherence to these disciplines. Girls were required to give up the "ways of the boys", learn the skills of womanhood for roles of wife and mother, become familiar with herbs and medicines required to maintain wellness or cure illness and seek their spiritual power through a vision quest (Attneave, 1979). Both male and female Shamen went through extensive and intensive quests and apprenticeships to learn the causes, cures and prevention of illnesses. The holis-

tic approach taken by both the Shamen and the peoples emphasized the saliency of the spiritual aspect of the being, as it was essential to physical, emotional and sociocultural wellness of the total person within her family and band. Amoss found in her study of the Nooksack Coast Salish that health was one of their chief concerns, and since health is considered a state of balance with nature and the supernaturals, and harmony among the spiritual, emotional and physical self, spiritualism functioned prominently in health concerns (Amoss, 1972). Childbearing, like puberty, has been viewed as a natural transition event: a state of health requiring special observances of rituals.

The birth rate among registered Indians in British Columbia has declined slightly in the past 10 years, but continues to remain higher than that for the total population of British Columbia. Rates of both low birth weight and infant deaths are in excess of the rates for the province as a whole. Today Native peoples are much more likely to die from acute causes than from chronic disease or old age. Accidents, poisoning and violence account for more deaths than any other cause for Native peoples of British Columbia (Health and Welfare, 1982); whereas major causes of death for whites are ischaemic heart disease, cerebrovascular disease and cancer (In Sickness & In Health, 1983). Of the 1500 fatal accidents experienced by registered Indians in British Columbia in 1982, 472 were alcohol-related, with 433 occurring to adults in general and six to pregnant women (Health and Welfare, 1982). It seems that traditional beliefs and values are not consistently practiced or integrated into contemporary lifestyle behaviors of the Native peoples.

Law (1983) noted that one of the main issues currently confronting all Canadian women was addiction - problems with the use of alcohol, drugs and tobacco. A national study of drinking practices carried out in late 1976 indicated that 82% of female respondents, 15-49 years of age, used alcohol and 49% had done so in the past week (Rootman, 1978). The average consumption of these women in the childbearing age was 3.6 drinks in the seven days preceding the survey, with 3.9% of the women reporting drinking the equivalent of two or more drinks per day (Rootman, 1978). Of the Canadian provinces, British Columbia has the greatest at-risk situation for alcohol problems. It had the highest consumption of alcohol in 1975/76, as reflected in retail sales of alcohol and the highest prevalence of cirrhosis of the liver (Rootman, 1978). Women over the age of 20, living in British Columbia, have the greatest probability of dying from cirrhosis of the liver (the best indicator of heavy drinking) compared to all other Canadian women. This corresponds fairly well to the per capita consumption rates computed from sales data and certainly indicates a serious at-risk situation for women of childbearing age.

Human Biology

"All those aspects of health, both physical and mental, which are developed within the human body as a consequence of the basic biology of man and the organic make-up of the individual" are considered human biology elements (Lalonde, 1974:31). Both paternal and maternal genetics and maternal prenatal lifestyle factors influence the human biology of the fetus. FAS has been identified as the third leading cause of mental retardation - a cause believed to be preventable. Physical and developmental problems have also

been identified among children born to mothers who have consumed excessive amounts of alcohol during the pregnancy (Landesman-Dwyer, 1979; Landesman-Dwyer, Ragozin & Little, 1981; Little, 1977). MacLeod (1983) also suggests that the high incidence of FAS noted among Native people may be linked more to parental genetics than to the amount of alcohol consumed.

Human biological factors may increase the susceptibility of individuals (mothers and/or fetuses) to adverse effects of an unhealthy lifestyle, or alter their vulnerability to supportive-nonsupportive aspects of the environment (Clarke & Driever, 1983; Rose & Killien, 1983), as well as increase their risk to adverse alcohol effects (Wolff, 1977; MacLeod, 1983).

Environment

The environment element includes all those matters related to health which are external to the human body and over which individuals, by themselves, have little or no control, eg. food and drug safety, changing social environment (Lalonde, 1974). The family, the primary sociocultural environment for Native people, can affect the health of the mother and fetus through such mechanisms as teachings, material aid and supportiveness. From a holistic, ecological perspective, the environment is a critical component of the change process (Moos, 1979; Lalonde, 1974). The family network, a microcosm of Native society, provides the supportive or nonsupportive sociocultural environment for individuals to engage in daily activities and transmit values, beliefs and practices to its members through family relationships within community life.

Specific childbearing behavior must be understood within the entire repertoire of lifestyle behaviors and situational contexts of the family. For instance, drinking alcoholic beverages has been a common practice among Canadian Indians. It has been viewed by many Indians as a cultural thing to do: an expression of "Indianness" (Lemert, 1956) but the socially complex behavior of drinking varies among and within tribes. It occurs within the context of other activities of daily living and within the family network that transmits expectations for both males and females regarding participation and drinking their share. To bring about change in a woman's lifestyle behavior, the values and beliefs, how they are transmitted from her sociocultural family environment and whether or not the family is supportive of change must be understood.

Health Care Organization

The health care organization is commonly defined as the health care system and consists of the quantity, quality, arrangements, nature and relationships of people and resources in the provision of health care (Lalonde, 1974) Although the Canadian Health Care Organization has been acclaimed as one of the finest in the world, Hastings notes that

> ...imbalance among services, inefficiencies in distribution, gaps co-existing with overlaps, and lack of coordination in planning and implementation continue almost as the rule (Hastings, 1975:62).

When the organization is examined in the context of Native peoples' health, a number of discrepancies and gaps are very readily apparent. Gaps in accessibility, accepta-

bility, comprehensiveness, continuity and quality of the health care delivery organization for Native peoples interact with individual and family susceptibility and vulnerability. Native peoples' disadvantaged position is seen in the results of their transactions with the environment: higher rates than the national population for acute health problems, childbirth complications, alcoholism and suicide (Indian and Northern Affairs Canada, 1980; Lalonde, 1974).

Historically, both preventive and curative health care services for the Canadian Indians was the responsibility of the Federal government. Recently curative services for Native peoples living on reserves have been contracted out to, or incorporated into, the provincial medical care systems, while preventive services on some reserves have been assumed by Bands and on others by federally employed Community Health Nurses who continue to be the providers of care. For those Indians not living on reserves, the provincial or regional health care delivery organization is supposed to meet both their preventive and curative health needs. The gaps in the health care delivery to Native peoples in Canada are not only a result of the variable jurisdictional responsibilities, but cultural gaps within the systems are apparent (Begin, 1980). The existing health care organization in Canada is perceived by many, including the Native peoples, as being disparate in it's accessibility and acceptability.

> What seems obvious, feasible, and desirable to health personnel, looking at the world with their own culturally tinted glasses, may seem quite otherwise to the people they serve. (Paul, 1969:32).

Problems with alcohol use among Native peoples have been clearly recognized by them, as well as by workers in the

health care delivery system, but there are few culturally relevant approaches to such health problems. An attempt to address some of the health and alcohol problems at the community level resulted in the establishment of the National Native Alcohol and Drug Abuse Program (NNADAP), jointly funded by the two federal departments: National Health and Welfare and Indian Affairs and Northern Development. In 1982, 47 projects were funded in British Columbia, an increase of 19 from 1981. The existing 28 projects were enriched to expand treatment and preventive services, and 43 alcohol and drug counsellors were added to the programs (Health and Welfare, 1982, 1981; Smith et al,1981).

Tribal councils, Bands and Native organizations have also been involved in providing culturally appropriate approaches to health care by sponsoring special training, workshops and conferences in issues of women, youth and the elderly as special needs groups. The association of FAS with childbearing lifestyle practices is beginning to be recognized and talked about. However, there is some reluctance on the part of the Native peoples to highlight this pregnancy outcome for fear that it will be labelled a "Native problem", such that the mention of FAS is immediately equated with Native peoples.

Unfortunately, there are few practicing health care professionals of Native background and the overwhelming majority of non-Native health professionals have little educational preparation or knowledge of the Native peoples' values, beliefs or practices (Waddel,1984; Horn, 1975). Although there is a national program to train Native peoples as Community Health Representatives (CHRs) or alcohol project workers (Health and Welfare, 1982), there are no Native-

oriented professional programs in nursing, community health or medicine. In British Columbia, all new and existing Community Health Nurses employed by Medical Services are provided with a cultural orientation through a variety of methods, but not necessarily by the Native peoples. Yet, according to the most recent annual report outlining Community Health Nurses activities, counselling and group education were their primary responsibilities. Activities were primarily centered around infant and child care, nutrition and prenatal education, culturally-determined practices (Health and Welfare, 1982). Many Native communities in the southern Pacific region of British Columbia have made frequent requests for parenting, sex education, child abuse, family life and mental health workshops. Clearly these areas of concern/ interest are intimately tied up with values, beliefs and attitudes within the family environment. The ability to influence changes in lifestyle behaviors and health services will only come about by those involved understanding the culture, which is best interpreted and taught by Native peoples themselves. Many Native women have identified the importance of respect and knowledge of their cultural norms as being a valuable asset for any health care person working with them: more important than knowledge and technical skills (Horn, 1975).But because it is not unusual for Native peoples to miss appointments, use health services mainly in times of crisis, fail to take advantage of primary preventive care and supposedly ignore prescribed health/medical regimes, there is a tendency for the health care professionals to become frustrated and feel they just don't care (Kennedy, 1961; Kennedy, 1984; Horn, 1975). Wilson states emphatically

> It is my contention that health programs for the Natives are not now, and will not be, effective until the sense of pride and power can be restored to the Native people and the shattered sense of self-worth is rebuilt, the effect of which is passed on from generation to generation (Wilson, 1983:1).

Using the Health Care Organization

In a review of trends in research on utilization of health services in traditional societies, Foster (1977) describes an important shift in the emphasis placed upon, or even the recognition given to, two different classes of constraints on the use of Western-style medical care. Earlier research, he finds, was primarily concerned with discovering ways in which the traditional culture, in particular Native medical beliefs and practices, acted to inhibit the population's acceptance of modern health care and the means of advising health personnel on how these "cultural barriers" might best be overcome. By contrast, more recent research, attempting to account for low utilization rates, has emphasized factors relating to how health services are provided. Bureaucratic complexities, the interaction style of practitioners and cultural gaps complicate the problem of elementary communication and impede the acceptance of health services (Paul, 1969). Cost and physical accessibility of health facilities and cultural appropiateness of the services increasingly figure in explanations of health-related behavior.

Foster (1977) suggests that this shifting explanatory emphasis is primarily due to changes in the study phenomenon itself, whereas Young (1981) accounts for the shift based on anthropologists' increasing concern with the role of extracommunity factors as determinants of local health care

decisions. The empirical findings from Young's Pichitaro research supported others' findings that traditional medical beliefs and practices no more represent a primary barrier to the use of a physician's treatment, than accessibility and accountability factors (Young, 1981). The increasing recognition of the Canadian Native health care situation may be due, in part, to a combination of these explanations.

Explanations that emphasize the inhibiting role of endogenous cultural influences place responsibility for underuse of Western health care services and accompanying poorer health levels directly with the people themselves. Such explanations suggest that the solution is to modify or change people's attitudes to health care. In the past, this has only partially explained the health status of Native peoples and has recently come under attack with the Native resistance to assimilation into the national economy, government and society and with the resurgence of cultural identity. On the other hand, explanations centering upon the accessibility and organization of health services places primary responsibility for low health status and rates of utilization with the providers of care. Based on the experiences of non-Native administered Medical Services Programs and Native directed and funded community health services, this perspective only provides partial explanation for the use of the health care organization. It is reasonable to assume that individuals' decisions concerning the use of Western medical and health care result from an interaction of both cultural and health care organizational influences and the transactions that occur between the Native peoples and the different sectors of the Health Care System.

By knowing the indigenous resources available to Native peoples and understanding their decision-making process, it may be possible to isolate reasons for use and non-use of particular alternatives. The Pacific Region of Medical Services had recognized that

> ...the challenge at this time continues to be the requirement to meaningfully involve Native people in the health service both as health care workers and as informed consumers. (Health and Welfare, 1982:6)

It has been well documented that health seeking behaviors are, to a great extent, influenced or determined by one's sociocultural background, and are variable within and between ethnic groups (Mears, Pals, Kuezerpa, et al, 1981; Lin, Tardiff, Donetz & Goresky, 1978; Chrisman & Kleinman, 1980). The social and cultural environmental factors are important dimensions of health care and health seeking behavior, in both preventive and curative spheres. These environmental factors are critical to the development and maintenance of all lifestyle behaviors, including that of childbearing and alcohol consumption. Values and beliefs that provide people with their ethnic identity are manifested in behavior: behavior that is often viewed as culture-specific and culture-appropriate.

How health and wellness, disease and illness and childbearing are defined and sickness explained, will determine how and when various sectors of the health care system are used (Kleinman, 1981; Chrisman & Kleinman 1980; Waxler, 1974). Native peoples' explanations for their states of wellness and illness and their process of seeking help have been found to differ considerably from other ethnic groups in British Columbia (Mears, Pals, Kuczerpa, et al, 1981;

Lin, Tardiff, Donetz, Goresky, 1978; Horn, 1975).

Childbearing: Its Cultural Relevancy

Pregnancy is a significant event in the life cycle of any individual or family. Childbearing practices can be considered as reflections of cultural values, beliefs and traditions found in the family environment. Mechanic noted that the understanding of how a group views health and disease depends to a great extent upon the social and cultural context within which life events and human problems are defined (Mechanic, 1968). The process of seeking health care will depend upon those sociocultural factors. The natural process of childbearing, with its associated practices, is well integrated into the activities of Native peoples' daily living, but many of the traditional childbearing teachings and practices, supportive of a healthy pregnancy, are not currently being practiced by the Native peoples. Those that are appear to be intimately imbedded in family traditional functioning (Lewis, 1970). Davis and Mayfield (1981) suggest that it is not only desirable, but also possible, to contribute to healthy well-adjusted youth and adults and maintain pride and awareness in Native culture and tradition by combining both modern developmental ideas and traditional childbearing teachings.

Among the Native peoples there are at-risk groups: at risk because they have been deprived of this knowledge either by having been removed from their family or not yet old enough. Approximately one third of Native infants are born to teenage mothers, many of whom have not developed the life skills necessary for successful childbearing and parenting (Davies & Mayfield, 1981; Attneave, 1979; Lewis,

1980; Ryan, 1980). Living with their extended family provides them with some protection against the risk factors.

Native peoples seek prenatal medical care less frequently than nonNative women and when they do, it is often late in the pregnancy. Attendance at general prenatal health education classes is rare for Native couples. Horn (1975) found that the health care system provided by professional health care workers was generally by-passed by Native childbearing women and utilized only in crisis . Religious and cultural beliefs and empirical knowledge were the basis upon which the women made decisions about health and health care. In some instances this belief system could be in conflict with the prenatal health care system to which they are exposed (Horn, 1975; Jordon, 1983). In order to reduce conflict one's belief system could change, or one could avoid the health care delivery system - not difficult when the systaem is neither readily accessible, nor comprehensively administered, and may be culturally insensitive and inappropriate.

One of the few studies (Horn, 1975) done among the Native Indian childbearing women found that members of one's family of orientation were expected to provide information and to offer psychological and material support during pregnancy. When they could not, the extended family members were expected to assume responsibility for meeting these needs. As in drinking behavior, the family provided the sociocultural environment in which lifestyle decisions were made. The extended, close-knit Native family provided a great deal of mental and emotional support, as well as physical help (Loughlin, 1969). Although a basic tenet of Native philosophy is individual autonomy, it is still the

prerogative of the mother and grandmother to advise and help when asked (Loughlin, 1969).

Nursing Research and the Childbearing Period

Within the present health care organization: as defined by Lalonde (1974), nurses, especially those working in the community, provide the major health promotion and primary prevention services to women during the childbearing period. Primary health care is their raison d'tere. If nurses are to diagnose and treat human responses to actual or potential health problems (American Nurses Association, 1980) they must be knowledgeable about the scope and causes of potential health problems and understand human responses in socially and culturally relevant contexts. Horn (1975) found that her sample of Native women described many experiences with prenatal care offered by professional health practitioners, including nurses, as being irrelevant as the women did not define pregnancy as illness. They apparently made efforts to obtain health care services only when it was culturally relevant to do so: when there was something irregular about their pregnancy. However, when the women did enter the health care system in the childbearing period, they reported little, if any, follow-up by the nurses. It is clear that culture-sensitive nursing care in diagnosing and treating responses to actual or potential health problems during childbearing is basic to health promotion for the family.

Jordon (1983) suggested that childbirth had to be understood as a sociobiological event. This framework could be expanded to view childbearing as a biosociocultural process significantly influenced by family environments and trans-

actions, and understood from an emic perspective. A nursing conceptual framework for childbearing, based in this premise, would require holistic, ecological and humanistic orientations.

The availability of data useful for a holistic conception of either childbirth or childbearing is almost negligible. Mead and Newton (1967) made an extensive search of medical and anthropological literature on birth practices. They found that medical reports were handicapped by physician's orientation to pathology and by the fact that doctors working in traditional societies tended to see only the cases of extremely abnormal childbirth. A review of the Human Relations Area Files revealed that almost two-thirds contain no mention or description of childbearing and normal birth. This may be due to the fact that childbearing, because it is predominantly female-oriented and female-dominated, has a low priority in the male dominated discipline of anthropology (Jordon, 1983).

Or it may be that:

> normal childbirth as it takes place regularly in tribal community is out of bounds for the physician as well as the anthropologist (Mead & Newton, 1967: 149).

Statistical compilations on such variables as infant and maternal mortality and morbidity, the availability of health personnel and facilities, and the nutritional and epidemiological status of the population are useful for planning within the health care organization, but they tell us little about the sociocultural interactional aspects of childbearing. Anthropological statistical studies give no mention of social relationships or cultural transmission,

while ethnographic studies dealing with such topics as kinship, ritual, conflict and belief systems, report little about the nature of decision-making processes used in the childbearing period or the extent or source of material, physical and emotional support during that period (Jordon, 1983).

Descriptions of pregnancy and childbirth are scattered throughout the ethnographic literature and more recently in medical and nursing journals, as well. However, McClain concludes from her extensive review that there is one major limitation to date:

> ...the lack of sufficient attention to pregnancy and childbirth as an ethnographic category (McClain, 1982:37).

The significance of the continuity of traditional practices is noted by Gonzalez and Behar in their study of childbearing practices in both Indian and Ladino groups in Guatemala (Gonzalez & Behar, 1966). Their findings suggest that culture change rarely totally suppresses traditional practices, but rather provides a source of additional alternatives. Thus, it is important to address both contempory and traditional beliefs, values and practices.

It may be very appropriate and acceptable for a female nurse-anthropologist to investigate beliefs, values and practices of childbearing woman from holistic, ecological and humanistic perspectives. Jordon (1983) argues that there are biological, as well as cultural reasons why women are uniquely suited for documenting, analyzing, understanding and teaching the birth process. This could apply to the process of childbearing as well. The rationale includes:

1. Birth is a private event with limited access as it is generally within the domain of the family or the woman's community. Access is more readily available to women than men.

2. Women are more likely to achieve the involvment, reciprocity and trust and likely to produce less disruption in the process than men. More valid data from investigations by female researchers can be expected.

3. Women, even those who have not given birth themselves, bring to the process a deeper and more fundamental interest than men, a principled interest which is grounded in the fact that their own bodies are built for this very same process.

4. It is widely believed that women inherently feel greater emphathy with the childbearing women than men do. Jordon suggests that women's ability goes beyond sharing somebody else's feelings and emotions to include the ability to share bodily processes.

> I would suggest that women, where the system encourages active co-participation, experience a physiological synchrony with the woman in labor which allows them to co-experience the event in ways fundamentally different from men. I base this conjecture not only on my own experience but also on the account of other female birth participants, who have reported that they find themselves matching the woman's breathing, pushing with her, and even experiencing uterine contractions, sometimes with the consequence of starting a menstrual period early ... intensive involvement sets up a physiologial sychrony in the female support persons which may have hormonal correlates. (Jordon, 1983:123)

An investigation of the childbearing period needs to include not only medical-physiological aspects but also the social-ecological factors that are instrumental in making childbearing a biosociocultural event. An indepth study of one culture's values, beliefs and practices that leads to the development of a framework relating concepts from a holistic perspective would contribute to future cross-cultural comparisons in childbearing.

Statement of the Problem

The question "What is culturally sensitive and appropriate health care for Native peoples during the childbearing period, care that recognizes their potential and real assets?" has yet to be answered by nurses as professional health care providers. This study considered the importance of the women's sociocultural environment in promoting a healthy childbearing process, while identifying both traditional and contempory childbearing beliefs, values and practices of Native women.

The problem addressed by this study is stated in three parts:

1. What are the cultural meanings Native peoples use to organize the childbearing experience and behaviors?

2. How do they interpret the outcomes of these behaviors and experiences?

3. What are the perceived family environmental factors that influence the ability to have a healthy pregnancy and baby?

The critical problem appears to be that data on childbearing practices of Native peoples are lacking to such an extent that deveplopment of appropriate health care to promote healthy pregnancies and their outcomes is severely curtailed. Yet the Natives' disadvantaged position in health status and low use of non-Native health and medical services indicates their at-risk position for experiencing adverse pregnancy outcomes. Problems appear to exist in and between each of the interacting elements of the Health Field Concept (Lalonde, 1974). However, how the Native peoples perceive aspects of these elements, the saliency of them and possible interactions related to childbearing is unknown. Leon (1968) mentions assets and potential assets inherent in the current Native health situation. He states

> The first and foremost asset is the Indian people themselves. In spite of the vicissitudes of their life since the white man came to this country, they have maintained considerable dignity, and many tribes have retained enough of their culture and their previously adequate child-rearing practices to continue to impart some feeling of dignity to the young, although how much this is so we do not know. This is an area where research is needed (Leon, 1968: 233-234).

A similar perspective is meaningful when considering the importance of childbearing and healthy children to the future of the Native peoples.

The Purposes of the Study

The purposes of this study are to answer certain questions related to the problem identified, to suggest directions for nursing theory development and to identify health care policy implications. The purposes can be identified as

General and Specific. These have been developed as follows:

General Purposes

1. to discover the Coast Salish Indians' view of traditional and contemporary health-related behaviors during the childbearing period;

2. to discover the types of health behaviors and range of practices that childbearing Coast Salish women engage in or change; and

3. to discover how these behaviors and practices are influenced by the family and cultural environment.

Specific Purposes

Childbearing beliefs and practices directly affect the promotion of healthy pregnancies for women and their infants, while alcohol consumption is ubiquitous to lifestyle habits even during the childbearing period. The association of drinking behavior with less than favorable pregnancy outcomes is neither well understood nor accepted by Native peoples. Therefore, a major specific purpose of this research is to discover the Coast Salish perspective of drinking behaviors, within the context of childbearing practices and related socio-cultural experiences (e.g. family functioning, tribal affiliation and Native identity).

In order to address these purposes specific research questions were generated.

1. What are some universal and unique characteristics - (e.g. demographic, geographic and cultural) of a Coast Salish Indian tribe?

2. What traditional beliefs and practices about the childbearing period and drinking behavior are known to women and men? How are women and men made aware of knowledge, values, beliefs and practices?

3. What contemporary beliefs and practices about the childbearing period and drinking behavior are known to women and men? How are women and men made aware of knowledge, values, beliefs and practices?

4. What is the drinking behavior and how has this changed during the childbearing period for women, men and family?

5. What family network supports or environmental stresses are perceived as influencing the maintenance or change of health-related beliefs and behavior?

6. What relationships exist among childbearing beliefs and practices, self-concept and ethnic identity?

7. How do individual perceptions, knowledge and practices compare with the population being sampled and other West Coast Native peoples?

Until these issues are understood, culturally sensitive and appropriate health care during the childbearing period will not be available, services will remain ineffective and the health status unchanged for Native families. This ethno-

graphic research deals with a comprehensive study of the Songhees Peoples, one band of the Coast Salish tribe living on Vancouver Island in British Columbia. Female and male members of other Vancouver Island Coast Salish bands were included to increase the depth of understanding; while for purposes of validation, several women of the other two tribes of Vancouver Island (West Coast - Nootka and Kwakiutl) were interviewed.

CHAPTER II

UNDERSTANDING CHILDBEARING FROM NURSING AND NATIVE PERSPECTIVES: TOWARD AN INTEGRATED MODEL

INTRODUCTION

This chapter presents a conceptual framework that integrates nursing and Native perspectives for understanding childbearing women in their environment. A holistic ecological approach is taken to contribute to the development of nursing science, especially in the areas of childbearing, culture and transcultural nursing. Following this discussion a review of the literature is presented on research approaches to the cross-cultural study of childbearing and self-concept, cultural patterns in health beliefs, values and practices and selected theories of environment, ethnicity, and learning.

In the now classic work entitled "The Structure of Scientific Revolutions", Kuhn (1970) wrote about how advances are made in science. There is a paradigm in science that determines the choices that are made, the problems which are regarded as significant and the approaches to be adopted in attempting to solve them. Kuhn submitted that revolutions in science occurred when there was a change in the basic paradigm or in that which governs what a profession does. Changing the viewpoints and conceptualizations of the discipline of nursing from a medical to a holistic paradigm changes not only the content but the very practice of the profession. A revolution in nursing is occurring; there is the recognition of the need for innovation and creation of a new paradigm: a paradigm of nursing that is scientific, humanistic, holistic, balanced and self-reflective (Choi, 1985). Much contemporary nursing research is based on a holistic and/or qualitative paradigm.

The biomedical paradigm of childbearing views the childbearing phenomenon with inherent biological risks, most appropriately managed by the application of scientific knowledge and technology. Cultural factors, when recognized, are interpreted as impediments to proper maternity care. They are also interpreted as acting synergistically with malnutrition and disease to adversely affect maternal and infant outcome (McClain, 1982). The proper mode of intervention in this paradigm is re-education of client populations; very seldom is there a suggestion of collaborative efforts between traditional and modern health care systems. The biomedical paradigm is indeed inadequate for generating theory and hypotheses related to a holistic perspective of Native woman and their environment.

A biosociocultural, holistic paradigm, on the other hand would take into account the perspectives, values and beliefs of the childbearing women and their families, their rationale for adhering to a variety of health regimens and the support required within and without the social network to promote healthy outcomes of pregnancy and childbirth. Perceptions and approaches to childbirth, which diverge from the scientific, biomedical paradigm, are salient to the holistic paradigm.

Fuller (1978), discussed the need to recognize the contribution of the biological, psychological and sociological sciences to the discipline of nursing,

> ... the uniqueness of nursing may be found in its unusual and simultaneous concern with the relationship of these several dimensions to a condition of health (Fuller, 1978:703).

One might also include anthropological conceptualizations as being appropriate, if not critical to develop a holistic approach, the core of nursing. Incorporating concepts from the sciences into the body of knowledge of nursing science is paramount to the development and testing of nursing theory.

Nursing's responsibility is to society; a society that is comprised of a panorama of cultures, ethnic groups and levels of wellness and illness. Of the plethora of nursing definitions, the one adopted by the American Nurses' Association (1980) seems most appropriate to both the historical orientation of nursing and the contemporary evolution of nursing theory: "Nursing is the diagnosis and treatment of human responses to actual or potential health problems" (American Nurses Association, 1980:9). The phenomena of concern to nurses are human responses to actual or potential health problems. In this study, the significant human responses explored are related to two fields of study: individuals (Native women) and environments (their families). Individual environmental responses include any observable manifestation of need, dilemma, occurrence, event, concern etc. that can be described. The human responses studied are concerned with individual and group behaviors related to childbearing, potential health problems and transactions between the woman and her family. The behaviors include health seeking behaviors, lifestyle behaviors and responses related to communicating and learning beliefs, values and health-related practices. The discipline of nursing assumes its responsibility for clinical practice, education, administration and research within an ever-changing, complex society.

Conceptual Framework

Although many nurse theorists have focussed, in one way or another, on the theories and concepts central to this study, none have redefined, synthesized or operationalized them sufficiently to be testable in nursing practice. The conceptual framework developed for, and within, this study reflects the need for a new paradigm for nursing. It takes into account the need for both an emic and etic cultural perspective; it is based on a symbolic interaction approach and it recognizes the goal of nursing as holistic health for Native childbearing women and their family environments. The underlying theories of self-concept, family environment, ethnic identity, health-related behaviors, cross-cultural communication, symbolic interactionism, cognitive dissonance and culturologic-systems theories of nursing have been adapted and integrated. It is hoped that this conceptual framework will contribute to the development of a new paradigm for nursing.

Cultural Perspective

Culture refers to that complex whole that includes knowledge, belief, art, law, morals, customs and any other capabilities and habits acquired by an individual as a member of a society. It is the environment of the childbearing woman and consists of technology, social structure and ideology which have arisen in response to environmental conditions, both physical and psychological. Shared assumptions about the nature of the physical and social world, the goals of life and the appropriate means of achieving them are communicated from generation to generation (Paul, 1969). The assumptions consist of standards:

standards for deciding what is, what can be, how one feels about it, what to do about it and deciding how to go about doing it (Goodenough, 1973).

Beliefs, values and practices are culture-bound, although some aspects of each may be common to other ethnic groups. Beliefs refer to those propositions or facts about experiences and phenomena that people accept as true on the grounds of evidence distinct from personal knowledge (Goodenough, 1963; Living Webster, 1977). They are the propositions accepted as guides for assessing the future, supporting decisions or passing judgment on the behaviors of others.

Values are any concepts referring to a desirable or undesirable state of affairs (Spradley and McCurdy, 1975). They are the prevailing and persistent guides influencing a group's thinking and actions regarding what modes of conduct or end-states of existence are personally or socially desirable or acceptable. They give expression to human needs by acting as standards to guide ongoing activities (Rokeach, 1973). People of common social and cultural backgrounds will share many common beliefs, but show differences in some personal value orientations (Goodenough, 1963).

Practices are habitual, usual or customary ways of living now and in the past, manifested in behavior or actions that can be observed or reported. They are related to but not always congruent with the values always congruent with the values and belief systems and knowledge of cultural rules and/or experiences.

Cultures vary, but within a group, cultural regularities recur in the members' various acts of perceiving, thinking, evaluating, and doing. Although the culture of any group is subject to constant change, many aspects of culture, at least ideologically, tend to persist, such as values and beliefs about health and childbearing. Acceptance, rejection or modification of one's belief system is not a random process, but depends on how a new idea is perceived by the individual, and how it accords with current cultural values, assumptions and social relationships.

Culture change refers to the modifications made by a cultural group in relation to internal and external life forces. It is a process of adaptation to reduce conflict and promote a healthy "fit" between peoples and their environment (Leininger, 1978). Acculturation, assimilation, rejection and marginality are four possible modes of culture change that affect health, lifestlye behaviors and health seeking responses (Berry, Wintrob, Sindell, and Mawhinney, 1982).

Acculturation is the adoption by one cultural group of the other. This process occurs when a given culture learns how to take on the behaviors of another cultural group, while maintaining much of its own identity (Leininger, 1978; Berry et al, 1982). Assimilation on the other hand, is the process of being taken in, with subsequent relinquishing of cultural identity and absorption into the larger society.

Rejection of the dominant culture by the non-dominant group occurs by either withdrawal from contact or influence or resistance to participate in the larger society; while marginality refers to the situation imposed by the dominant

group through a combination of cultural loss and exclusion from major participation (Berry, et al, 1983).

Environment

Environment is the context within which human behavior patterns occur and learning takes place. It consists of physical, biological, sociocultural and psychological aspects, including beliefs, values and practices. The family environment is the primary source of culture transmission for the individual. Through culture, and thus through the family, individuals revise and interpret their complex environments and assign significance to events. Their perceptions of events both influence, and are influenced by, the behavior of others with whom they interact, as the cultural patterns of the family environment mediate between individuals and their larger environments. To a great extent the degree of person-environment fit, or adaptation, can be understood through understanding transactions that occur between individuals and their family environment.

Transactions are reciprocal symmetrical or asymmetrical exchanges between two sys' m - e.g. individuals and their environments, where one system influences another target system, while at the same or another time being influeced by it and ad infinitum in a never ending process. Transactions result in adjustments or adaptations made by the individual and/or environment, which affect feelings of wellness or illness or signs or health or disease. The adjustment has been termed the person environment fit (French, Rogers and Cobb, 1974).

Within the Canadian Indian Culture, the extended family is the social organization which provides the immediate environment for the development of self-concept and ethnic identity. It has the potential of providing dimensions of social support and/or stress for the individual member.

Adjustments

Wellness is the subjectively perceived assessment an individual makes about her ability to live optimally in a holistic way: physically, mentally, socially, spiritually and culturally. It draws its form from tradition and its substance from a system of concrete ideology (Lambo, 1980).

Similarily, illness refers to the perceived experience and meaning of disvalued changes in states of wellbeing and of social responses to abnormal functioning. Perceptions of illness may include one or any combination of changes in the individual's physiological, psychological, social, spiritual or cultural status (Kleinman, 1980; Eisenberg, 1977). Illness may occur in the absence of detectable organ pathology.

Disease on the other hand, refers to a malfunctioning of biological and/or physiological processes of body organs and systems generally explained by professional practitioners using a biomedical model. Disease may occur in the absence of perceived illness (Kleinman, 1980).

The objective assessment of an individual's ability to transact with the environment and function effectively - physically, mentally, socially and culturally - is defined as health. It is based on criteria developed by others,

often professional practitioners who may be of a different culture and social background and deal primarily with disease.

When individuals encounter people who hold different perceptions of their adjustments, it interferes with the orderliness and predictability of their social and physical world. A dissonance is created. Adaption to this dissonance may require change in one or both elements of the person-environment unit.

Childbearing

Nowhere in a culture are there usually more persistently prescribed rituals and ways of behaving as found in childbearing and childrearing. No known culture ignores or treats childbearing with indifference. Every aspect of social life is touched. All societies tend to regard childbearing as a significant biological event, to ritualize it, and to recognize certain psychological and social-cultural aspects of it. These include expectations of the roles of parents, emotional and physical responses, supporting behaviors from family and friends, and development of relationships between parent and infant.

For the purposes of this study, childbearing is the period from conception through birth, including the decision or non-decision to become pregnant.

Adaptation

Adaptation to both the transitional period of childbearing and to any inconsistencies or incongruencies in environ-

mental expectations will be required by all persons involved in the childbearing experience. Personal adaptation requires development and use of individual coping abilities, motivation and maintenance of wellness. This personal aspect of the transactional process relies, in part, on the individual's self-concept. Sociocultural adaptation involves the transmission of cultural solutions and traditions, mobilization of social and family networks, and responses by the community. This aspect of the transactional process is, in part, the result of ethnic identity and the situational pressures experienced by the individual.

Self Concept

Self-concept is organized around the beliefs and feelings that one holds about oneself at a given point in time. It is based on one's past history (beliefs, feelings, interactions), expectations of the future, and social interaction. Body image, self-esteem, role and identity are integrative categories of one's self-concept, both influenced by, and influencing the childbearing period experiences.

Ethnic Identity

Ethnic identity refers to the way members of a group categorize themselves in reference to others and attempt to associate or disassociate with persons whose culture is similar. It includes acknowledgement, support and transmission of cultural content, historical experience, and group image. The resurgence of an Indian identity is reflected in the Native Peoples' lobbying for self government and episodic response to, and use of, the

Western-oriented health care system. Ethnic identity is not to be confused with encouraging a stereotype.

A stereotype is an image of a particular group generally accepted within the broader culture or society (Forchuk, 1984). Stereotypes have the following characteristics: highly exaggerated picture of a few characteristics, invented traits made reasonable by association with other traits that have a kernel of truth, and failure to show how the majority share these traits (Simpson and Yinger, 1972). Ethnic identity is associated with pride, knowledge of Indian ways proven successful in the past and commitment to traditionally oriented beliefs, values and practices incorporated into contemporary living situations.

Native Peoples

Native Canadian Indian, Native Peoples, Canadian Indian are indigenous persons of Canada whether they be registered or non-registered, status or non-status, and living on or off a reserve. For reasons of respect and simplicity a person was considered to be Native if she identified herself as such in this study. To find out if an individual is an Indian, one need only ask as always the Indian people will proudly identify themselves (Attneave, 1979).

A Nursing Perspective

A nursing paradigm requires not only a re-oriented focus to the integration of mind-body-spirit-environment, but attention to behavior within the present cultural context of the changing demands of daily living, as well. This is reflected when nurses take an ecological perspective: con-

cerning themselves with understanding the interdependent, reciprocal relationships of human populations, environments, transactions between the two and resulting cultural patterns and health-disease outcomes (Duncan and Schnore, 1959).

Nursing practice that aims to promote high level wellness during the childbearing experience and seeks to alter individual health practices and attitudes must consist of cooperative efforts that involve the individual, family environment and the local culture. Nurses working with Native Indians during the childbearing period, by providing more culturally relevant and acceptable care to the childbearing woman and her family, should be able to reduce morbidity and mortality.

Culturally relevant nursing care that recognizes the holism of childbearing and its interrelations with the family environment must have its theoretic, etic foundations firmly developed from empirical, emic evidence. A holistic approach combines existentialism with a phenomenological method to learn about a culture or other subject matter in its entirety, considering the subjective qualities of the phenomenon under study (Stevens, 1979; Parse, 1981).

Health, like culture, is only "real" to the people who live it and report it. What is collected, interpreted, analyzed and categorized in research is the investigator's perspective. Although the data come from the people, and certain notions and ideas stand out, it is the investigator's interest, bias, knowledge, and experiences that puts the data in a structure. Investigators conducting descriptive research tacitly adhere to theoretical frameworks which guide

types of observations made, methods of gathering information, analysis and presentation of data (McClain, 1982).

A Native Perspective

A holistic approach is advocated by the Native peoples as evidenced in one Northwest Coast tribe's definition of health.

> Health has a less tangible dimension, not demonstrable by death or disease statistics, yet just as real and possibly more important. It is 'whole health', involving spiritual, social and mental aspects of the life of the individual and the community. It is 'health as strength' ...as togetherness, as harmony with the universe, as self-esteem, pride in self and group, as reliance, as coping, as joy in living.... (Penner, 1983:34).

The Medicine Wheel is a traditional way of interpreting health that is as meaningful to the Native peoples today, as it was to their great grandparents. Storm (1972) describes the Medicine Wheel as a way of life of the people: their philosophy of life and understanding of the universe. It is a way to become whole people, culturally, socially and environmentally. All things are contained within the Medicine Wheel, and all things are equal within it. Figure 1: Medicine Wheel: Directions of Understanding. Storm states

> ... all things within this Universe Wheel know of their harmony with every other thing... all have spirit and life... but it is only man ... who is a determiner. Our determining spirit can be made whole only through the learning of our harmony...To do this we must learn to seek and to perceive (Storm, 1972:5)

The following tenets of the Medicine Wheel reflect the wholeness and synergism of the model.

The Medicine Wheel has four directions representing physical, emotional, sociocultural and spiritual aspects of wellness. Each direction is made up of a number of elements which transact with each other within, and between, Medicine Wheels.

The woman herself is considered to be a Medicine Wheel within a larger family one. At the inner core of the individual's Medicine Wheel is her self-concept; influenced by every aspect of her lifecycle and environment. Her ethnic identity is an outcome of her continuous transactions with her environment, especially that of her family.

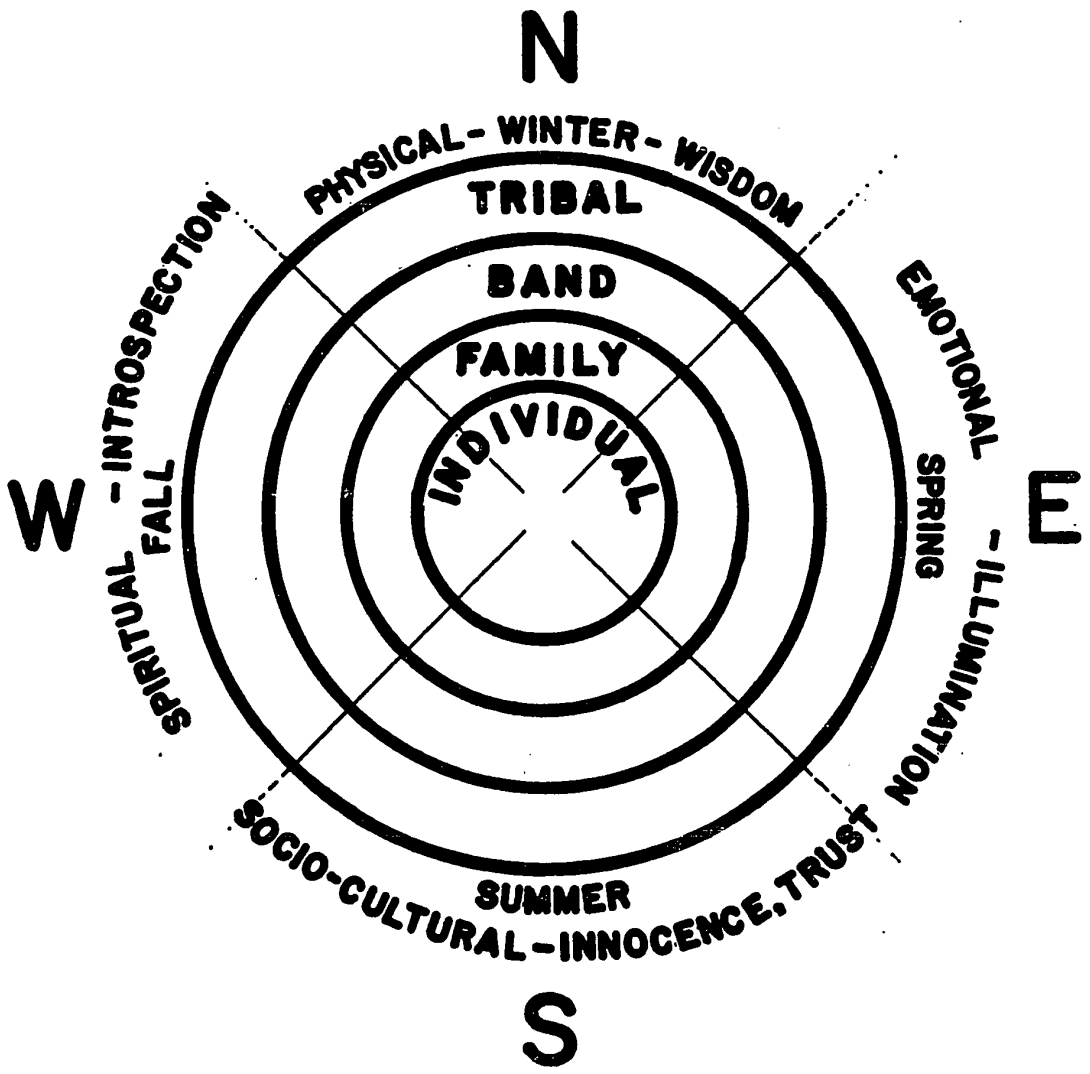
The family environment, a semi-permeable Medicine Wheel, influences transactions which occur between the individual woman and her greater environment. The transactions are continuous throughout life, rather than episodic. Family processes which influence this are communication, teachings of disciplines, and support.

The greater, more complex environment can be considered a Medicine Wheel. It includes cultural values and beliefs which can only be understood within the context of historical and contemporary milieu.

During any part of the lifecycle (e.g. childbearing), health and wellness are experienced when there is a balance between the individual and her environment and among the elements of the Medicine Wheels.

FIGURE 1

MEDICINE WHEEL: DIRECTIONS OF UNDERSTANDING



Integrated Model

Based on the nursing and Native perspectives of health and childbearing, a model was developed for providing initial and ongoing direction during the data collection phase of the study and for generating categories at the time of content analysis. Figure 2: Medicine Wheel and Coast Salish Childbearing: Directions and Elements. The model has been adapted from the Native Medicine Wheel concept to include both the emic, empirical foundations and the more theoretic, etic considerations. This distinct approach to the symbolic dimensions of childbearing attempts to synthesize the individual, social and cultural levels of conceptualization within a single analysis while preserving the Native perspective.

Review of the Literature

While the review of the literature assisted with the development of the conceptual framework and integrated model, it was also the conceptualization of the elements that directed the review. A conscientious effort was made to use a broad scope of resources, as well as investigate each resource in depth. Therefore, the literature review included not only scientific and professional writings, but folk and lay literature written by Native peoples and historical documents in the files of Native organizations and provincial archives. The review of the literature is organized around the concepts of childbearing, self-concept, environment and ethnicity, health beliefs, values and practices and finally selected theories of communication, learning and cognitive dissonance.

Childbearing - A Biosociocultural Experience

The formal transition to motherhood holds special meaning for women. Childbearing is everywhere an opportunity for consensual shaping and social regulation, the particular pattern depending on local history, ecology, social structure, and technological development (Jordon 1983). From an anthropological perspective, ethnic identity and degree of acculturation are factors in patterning.

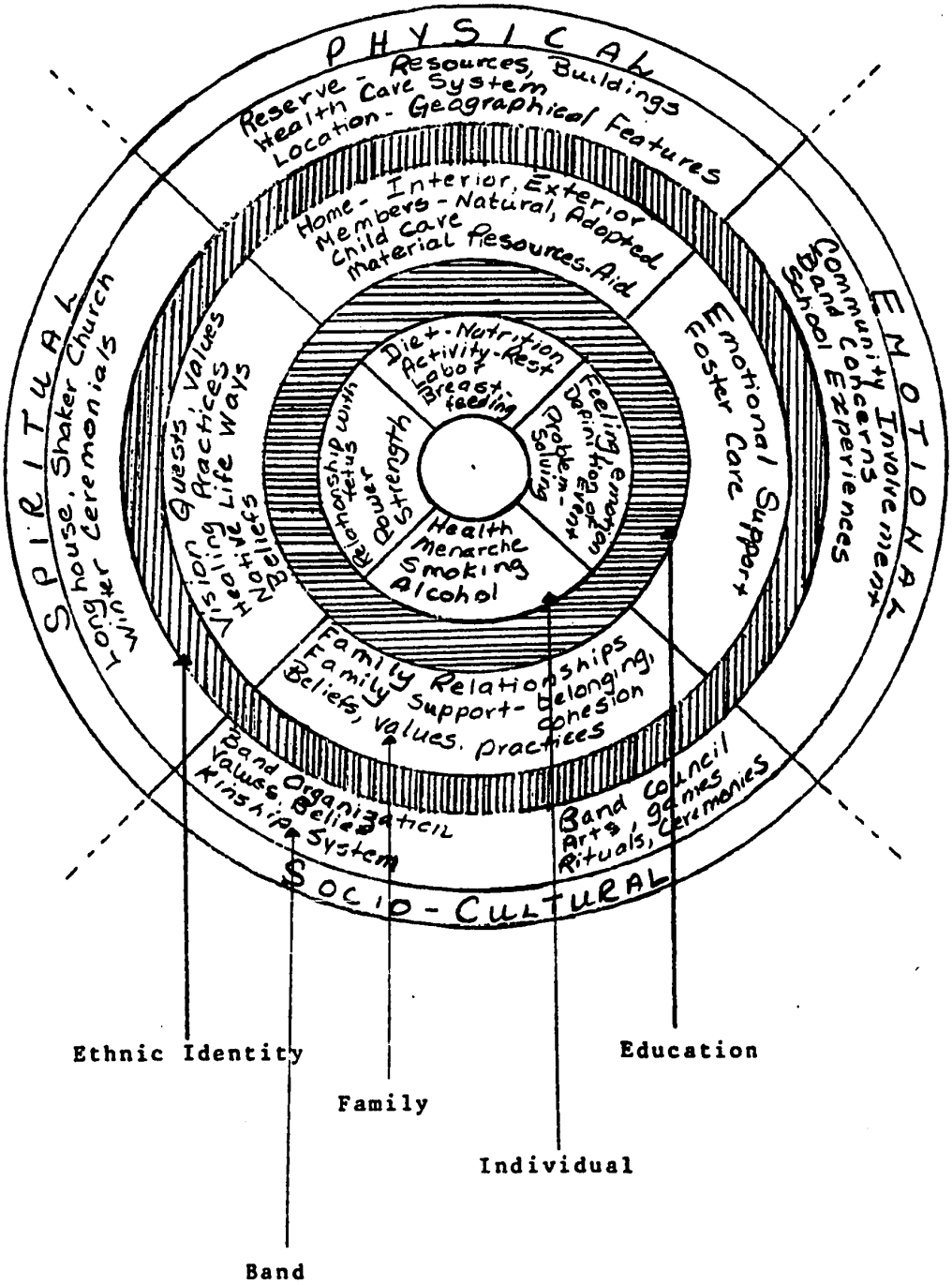
Cross Cultural Studies

Cross cultural evidence suggests that birth is universally treated as a life crisis event but that the childbearing period also provides an opportune time for shaping and social patterning (Jordon, 1983; Clark, 1979; Aamodt, 1978; Benedict, 1934; Mead & Newton, 1967). It is also a time of vulnerability for mother and child; indeed, frequently a time for ritual and danger for the entire family or community (Jordon 1983). In order to deal with this danger and existential uncertainty, people tend to produce a set of internally consistent and mutually dependent practices and beliefs, which are designed to manage the physiologically and socially problematic apsects of childbearing in a way that makes sense in that particular cultural context.

McClain (1982) reviewed five cross-cultural surveys of childbirth which thoroughly covered the ethnographic literature. She discussed the author's theoretical orientations, their assessment of cross-cultural diversity and its signficance, as well as each survey's major contribution to a comparative and holistic framework for viewing childbirth. The five surveys that were so comprehensively

FIGURE 2

MEDICINE WHEEL AND COAST SALISH CHILDBEARING



reviewed were 1) Clellan S. Ford's "Comparative Study of Human Reproduction" first published in 1945, 2) M.F. Ashley Montagu's exposition of Australian aboriginal and other nonwestern concepts of embryology and review of the history of embryology in the West, entitled "Early History of Embryology" and published in 1949 by Ciba Symposia, 3) Robert Spencer's "Primitive Obstetrics" also published by Ciba Symposia in 1949-50, 4) Margaret Mead's and Niles Newton's classic "The Cultural Patterning of Perinatal Behavior", published in 1967, and 5) Ann Oakley's "Cross Cultural Practices", a comparison of obstetrics in Europe and the United States with practices of more traditionally orientated societies, published in 1977. Carol McClain concludes that there is a lack of effort at systemization; a piecemeal approach has prevailed. Furthermore, the surveys have failed to show **childbearing** as an integral system of beliefs, values and behavior.

Cultural Imperatives

Culture is especially significant in the childbearing process because it defines the meaning of the experience and dictates how those involved are to react to the events (Auvenshire & Enriquex, 1985). In no known culture is pregnancy ignored or treated with indifference. Instead it invariably elicits a variety of emotions and feelings. Pregnancy may be viewed as an important signal of sexual adequacy, as a time of vulnerability and debility, and/or as a time of shame and reticence (Mead & Newton, 1967).

It appears that all cultures have beliefs concerning appropriate behavior throughout pregnancy, birth and peurperium (Auvenshine & Enrique, 1985). Cultural patterning regu-

lates such aspects as spacing of children, diet during pregnancy, support given to the woman during childbearing, medicines allowed and immediate care of the newborn, as well as dictating attitudes about childbearing in general (Benedict, 1934). While regarding childbearing as a significant biological event, society also recognizes its psychological and social aspects. Roles of parents, family and friends are defined with behavioral expectations delineated. Most commonly there are feelings of responsibility and accountability on the part of parents and feelings of solicitude on the part of the social group.

Childbearing represents a test of future mothering abilities (Deutscher, 1970) and the woman's perceptions of her mastery of the experience influences her perceptions of herself (Humencik & Bugen, 1981). A woman's perceptions of her mastery of the childbirth experience may be affected by her knowledge of the process and cultural expectations, coping skills, support from others, participation in decision-making, and availability of appropriate care (Humenick, 1981). Her self-concept, at the core of her being, both influences, and is influenced by, the biosocio-cultural childbearing experience.

Individuals view childbearing within the context of their cultural environment. Cultural values and beliefs about the childbearing role and its associated expectations touch every aspect of the woman's personal and social life. They determine whether childbearing is treated as a natural event in the life cycle, or as an illness, with the subsequent assumption of the sick role. Appreciation of the impact of the childbearing experience on women's lives will have to include understanding of the organization of social

networks, cultural rituals, personal coping strategies, including decision-making, and learning opportunities: aspects of personal and person-environment experiences.

Components of a cultural system

Four components of a cultural system are relevant to developing a framework that incorporates personal and person-environment transaction experiences with childbearing. Aamodt, (1978) discusses the importance of understanding the moral and value system, the kinship system, the knowledge and belief system and the ceremonial and ritual system as they relate to childbearing.

The **moral and value system** of a society provides a measure of social control and underlies many, if not all, of the judgments members of a community make with respect to their own behavior as well as that of others. Relevant cultural rules involve notions of duty, desirability, and obiligation.

> The value of taking care of oneself and the obligations of the individual to know about and make decisions 'to do what is right' are probably emphasized more in the activities surrounding the childbearing process that in any other practices that attempt to meet the demands of the human condition (Aamodt, 1978:13).

The **kinship system** refers to categories of reciprocal rights, duties, and obligations of role behavior for all relationships which result from marriage and family life in society. Who marries whom, who is responsible for child care, and who transmits information on childbearing are issues that relate to a cultural understanding of childbearing (Aamodt, 1978).

Processes of acquiring childbearing **knowledge and beliefs** are culturally defined and important to the transmission within and between generations. Various culture-specific theories of pregnancy, conception, and childbirth may exist side by side with proven scientific explanations; at times they produce degrees of cognitive dissonance for decision-making and carrying out health-related behaviors.

The **ceremonial and ritual behaviors** give testimony to the other three components of the cultural system. They provide the means for reenactment of the relationships of the symbolic elements in the cultural system and allow for the incorporation of the sense of meaning into daily lives (Aamodt, 1978). Ceremonies and rituals are frequently developed in a society for such life cycle events as puberty, courtship, marriage, pregnancy and childbirth. Rituals for pregnancy and childbirth may be concerned with prescriptions for changing roles of both the mother and father, as well as social relationships. The rituals provide guidelines to various members of the society regarding their allowed proximity and obligations to the mother and later to the infant (Aamodt, 1978).

Biosociocultural Framework

A biosociocultural framework provides an orientation to pregnancy and birth as culturally defined and socially organized processes which give meaning to the biological event. It is within this framework that childbearing behaviors can be explained as cultural responses to environmental forces. The cultural context in which childbearing occurs provides norms that influence attitudes, values and interpretations of personal and interpersonal

experiences. The culture provides implicit and explicit codes of behavior to follow and guidelines for expected responses of others.

Attention to women in their social organizations - family and society - has been ignored in much of the ethnographic literature (Rosaldo & Lamphere, 1974). Yet, childbearing and giving birth are essentially and uniquely women's business in most societies. An ethnographic investigation of the childbearing period provides an opportunity to assess Native women's ways of organizing and accomplishing their business at hand (Jordon, 1983).

While pregnancy and childbirth are being examined more frequently from the perspectives of decision theory and network analysis, the data are usually embedded in more general studies (McClain, 1982). Yet these are critical dimensions for nurses to understand. For Native women, childbearing has not been merely an epiphenomenon of female biology, nor a medical event, but rather perceived as a holistic phenomenon: a part of their normal lifecycle and sociocultural system which increases their level of wholeness. The Native culture expects women to be responsible for choices they make throughout the life cycle and lead a life supportive of personal and family growth.

This view contrasts with the contemporary Western definition of birth as a bio-medical event where research is focussed on the physiological and often the pathological aspects of childbearing. The physiological process of parturition are in some sense, everywhere the same, but practices differ among cultures and often differ strikingly from the Western medical model. To understand these

differences, a holistic, comprehensive view of childbearing is required which includes the social-interactional and sociocultural foundations of childbearing (Jordon, 1983).

At the present time, traditional systems are changing under the influence of Western medicine, while Western practices themselves are under pressure to adjust to changing views of the position and competencies of childbearing women and couples. The appropriateness of the medical model for the childbearing period has come under question by actual and potential consumers. Although safe, pain-free childbirth and a "natural" childbearing process is desirable in most societies (Scarletta, 1984; Jordan, 1983), the preoccupation of medical systems with the relief of pain by drugs and surgical interventions has alienated many families (Rothman, 1981; Oakley, 1976; Romalis, 1981; Jordan, 1981). Antithetical to this are recent studies which challenge the the safety of painfree medically managed pregnancies and births (Oakley, 1976; Romalis, 1981). The alternatives requested are for socially and culturally appropriate non-medical perinatal counselling and education, midwives who would provide health care services to women and their families during childbearing and birth, and choices in the management of the childbearing and parturition process. How these suggestions for change will be addressed will depend upon the extent to which a holistic framework is used and whether or not childbearing is viewed as a biosociocultural process.

It is proposed that childbearing be viewed as one of a number of systems or processes in a culture (Kay, 1982). To understand a cultural process, it is necessary to know the significance of behavior against the background of

motives, emotions, and values that are institutionalized in the culture (Benedict, 1934). Major shifts in social organization, particularly the structure and function of the family, causality beliefs and allocation of power in the political and economic systems, or in the health care sectors can affect beliefs and practices of childbearing (Kay, 1982). In order to understand why childbearing is managed in a particular way, the social organization, the political and economic system, and the causality theories of the culture must be appreciated. Childbearing beliefs and practices taken outside the social context become lists of folkways, interesting in their variation, and useful for symbolic analysis, but unsuitable for interpretation of human behavior.

Environments

The situational context in which the childbearing experience occurs and cultural expectations transmitted can be considered from an environmental perspective. Hall and Fagan (1968) point out, however, that the general problem of specifying the environment of a given system, or individual, is far from simple. In the behavioral disciplines it is difficult to determine which variables are essential to the person-environment fit to dichotomize them into system and environment.

Women - Environment Continuum

To a large degree environments are socially labelled and defined, mediated by cultural interpretations and meanings. These cultural meanings guide and limit the woman's transactions with her physiological, biological, physical and

social worlds (Knutson, 1965). Ethnic identity provides the primary terms by which people structure their environment and govern relations with others (Epstein, 1978). Attachment to kin and participation in close friendship circles serves not only to define the boundaries with which one identifies, but also provides an important mechanism for boundary maintenance with the environment.

The relationship between the concepts of environments and individuals can be theoretically described as a continuum. Figure 3: Woman - Environment Continuum. At one extreme is "woman as environment"; at the other end is "woman in environment". The concept of "woman as environment" is particularly salient to discussions of childbearing. Conception, fetal development and labor and birth are significantly influenced by maternal lifestyle behaviors, prenatal health and biology and prenatal factors such as disease and illness, poverty and prenatal care. The approach that the woman exists within an environment takes into consideration those objects or events with which she has contact in any particular context. Environments, in this respect have been defined as social, cultural, biological and ecological.

Figure 3: Woman - Environment Continuum

Woman As Environment ——————————— **Woman In Environment**

Approaches to "Woman in Environment"

The **social approach to environment** can be conceived as a system of interpersonal stimuli exerting influence on the individuals within that environment (Kiritz and Moos, 1974; Wolf, 1981). The influences can be categorized on three

dimensions: relationships, personal development, and system maintenance and change. These influences do not act directly on the individual, instead it is the perception of the social environment, as mediated by personality variables, role and status relationships and behavior within the environment, that directly affects the individual. The effects can be observed as physiological and behavior changes. The social approach tends to take an "interaction" perspective and views the environmental forces as impinging upon the individual, who then responds (Wolf, 1981). It ignores the individual's capacity for decision-making and responsibility for determining her behavior.

Within the broader **cultural framework,** the individual is seen as a prime and highly efficient instrument for adapting to and controlling the environment by utilizing and transmitting culture (Logan and Hunt, 1978). Human adaptation within the environmental parameters is a mutually interactive cultural and biological process (Alland, 1970). The woman is seen as changing her environment through culture: through beliefs, values, and practices that support an ethnic identity. This changed environment then acts on her physical structure and behavior, affecting feelings of wellness and illness, or states of health and disease. Although woman is viewed as a more active participant in the cultural environment, the concept of transaction is limited in this approach.

From a **biological point of view,** the environment is all that immediately surrounds an individual. The maintenance of life and health of the woman is regarded as being dependent upon a constant interaction between her and her envi-

ronment. Hinkle (1973) described this from a systems perspective as the maintenance of a dynamic steady state over a limited period of time by the consumption of free energy and by the continual interchange of matter, energy, and information with the environment. The biological environment perspective has been used to explain physiological processes that may be created by neural regulatory mechanisms, such as stress (Hinkle, 1973). The aspects of the environment that do not impinge upon the woman directly, but are at a distance in time or place, or are involved with other people and social groups are not included in this perspective; nor is the concept of transactions included.

Bronfenbrenner (1979), taking an **ecological perspective,** defined environments as extending to incorporate interconnections between settings, as well as to external influences emanating from the larger surroundings. Interaction of woman with environment is viewed as a twodirectional process of mutual accomodation characterized by reciprocity, similar to the concept of transaction. Because it takes into account levels of systems within the environments, the ecological perspective assists in understanding human development and examining multiperson systems of interaction (Bronfenbrenner, 1979). Bronfenbrenner (1979) stated that in ecological research properties of the person and environment, the structure of environmental settings and the processes taking place within and between them must be viewed as interdependent and analyzed in systems terms. An ecological perspective incorporates both systems theory and the concept of transactions. It could be expanded to include a holistic orientation that takes into account the

individual's perceptions, and the phenomenological environment.

An individual never functions in a single environment, but in many overlapping contexts, which in turn provide varying degrees of support, resources, restraints, costs etc. It is necessary to understand the impact these interacting dimensions and environments have on the woman and she on them, from her perspective as well as from an etic one.

Woman as Environment

Considering "woman as environment" takes the approach that subsystems of the woman transact together within her total milieu, and that this transaction affects her behavior as well as her behavior affecting the transactions. This perspective, based on systems theory, is congruent with that of Schwartz (1979), Lazarus (1975), Levi (1975) and Thomas (1974). The concepts of communication, feedback and self-regulation define elements of the transaction process, while information provides the necessary input. In order to understand how any system works as a whole, it is necessary to study its behavior as a whole: the input, the combinations, interactions, patterns of the elements of transactions and the adaptations (Schwartz, 1979).

Levi (1975) suggested that both psychological and physiological parameters of emotions are subjective states with adaptive potentials for the individual. Studies on emotions in relation to stress illustrate the intricate and complicated **feedback mechanisms and information exchange** required for self-regulation of behavior. The emotions, resulting from transactions of subsystems of the individual

or from individual-environment interaction, act as feedback mechanisms or self-regulators for behavior. The goal of this behavior is to improve individual-environment fit. The accuracy of early subjective diagnosis of pregnancy (Jordan, 1977) may be partially explained by this conceptualization of information exchange and feedback among subsystems.

The **idea of perception** is critical to the concept of self-regulation of subsystems transacting with each other and the whole. Perception is a taking in: an acknowledgement of stimuli, either consciously or unconsciously. Subsystems may perceive environmental stimuli through a variety of sense responsive mechanisms. Schwartz (1979) proposed that the brain engages continually in self-regulatory behavior, most of which occurs at an unconscious level, for the purpose of maintaining the health and well-being of itself and its body. Individuals may become this self-regulatory process when the feedback is registered in consciousness. Thomas (1974) provided a graphic description of this phenomenon in "Lives of a Cell" when he developed his themes of synchrony, holism and communication for the individual, subsystems and environment. The concept of "woman as environment" is an evolving one, but important to the understanding of woman-environment transactions in the childbearing period, as the woman is the environment for the fetus: a significant perspective in the Native way of life. The perspective taken to environment in this study is an ecological one that incorporates individual's perceptions.

Woman - Environment Fit

The impact and interrelation between the environment and the individual are interactive and focussed processes, with a goal of congruence or fit. Well-being and adaptation are considered to be functions of the degree of fit or congruence between the dimensions of the environment and the needs and preferences of the individual. French, Rodgers and Cobb (1974) conceived of adjustment as the goodness of between characteristics of the person(s) and the properties of her environment(s). They identified four criteria for predicting the mental health of a person at a given time: her objective p-e fit, her subjective p-e fit, her contact with reality and her accuracy of self-assessment.

Although Nehrke and collegaues found that congruence dimensions of their Environmental Perceptions, Preference and Importance Scale (EPPIS) were significant predictors of well-being among institutionalized elderly, it was suggested that fit is a necessary but not sufficient condition for well-being (Nehrke, Turner, Cohen et al, 1981). Decreasing the discrepancy between important environmental and individual variables should theoretically create conditions supportive of increased levels of well-being. However, other significant person-environment variables mediate high level wellness including perceptions, recognition, motivation, coping skills and resources (Moos, 1979; Becker, 1974). Techniques for adjusting, reducing dissonance, and increasing a sense of well-being may be powerfully influenced by the woman, her family environment, and the transactions between the two.

The Family Environment

The family provides the most immediate holistic environment for the childbearing woman. It acts as mediator of both past and present cultures. Transactions of the childbearing woman with the family environment can be viewed as bidirectional processes of mutual accommodation. The biological, social and cultural factors, as well as the transactions which occur among family members and the woman, are important variables in understanding behaviors in childbearing. As the primary molder of culture, the family conditions attitudes, beliefs, and values about personal relations, time and work orientations, education and processes and events in the life cycle (Mithun, 1983). Both families of origin and procreation provide environments for belief, value, and behavior transmission. Mithun (1983) states that family patterning may affect an individual's adaptive potential and cultural integration within the larger society. The psycho-cultural and behavioral dimensions of the family of origin are important factors in culture change processes as family environments may be supportive or non-supportive for certain types of behaviors.

A holistic perspective of family environment is consistent with the holistic perspective that Native peoples have regarding health. The family is the smallest socio-cultural unit which transmits beliefs, values, and knowledge required for appropriate behavior (Levine, 1982). It does so through family transactional patterns of repeated interactions of how, when and to whom to relate, of roles and tasks required for healthy family functioning and of behaviors appropriate to stages in the lifecycle.

Within the family environment, family members contribute to, or make behavior possible; at the same time the family is affected by the individual member's behavior (Steinglass, 1981). Alcohol consumption behavior provides an example of this transaction. The environment of the alcoholic family of origin provides genetic, health and social risks for the woman to develop alcohol problems later in life (Hill, 1980; Wolin, 1980). Compared with non-alcoholic women, Boothroyd (1980) found that alcoholic women were more likely to have had heavy drinking mothers, alcoholic fathers, psychiatric illness among their female relatives, early parental deprivation and "broken" homes before the age of ten. Family of procreation studies have identified variables such as husband alcoholic, unhappy marriage and rigid family stereotype behavior as significant environmental factors contributing to alcohol problems in women (Boothroyd, 1980; Steinglass, 1981). None of these studies included a Native sample.

Caplan (1976) proposed that **families** acted **as support systems** with functions related to acceptance, affective development and aid. Support required for individual and family health has not been explicitly defined. Many empirical investigators have used the term social support with little or no definition and included numerous untested assumptions (Macelveen-Hoehn & Eyres,nd). There is however, an underlying assumption that social support includes components identified by Cobb (1976). His emphasis was on information rather than goods and services; that is social support is information leading the individual to believe that she is cared for and loved, esteemed and valued, and belongs to a network of communication and mutual obligation. House (1981), on the

other hand, defines social support as interpersonal transactions involving at least one of the following: emotional concern, information, appraisal and instrumental aid. This perspective is more comprehensive when considering the social support function of the family as environment, but still omits several aspects identified by other authors. Providing opportunities for nurturing (Weiss, 1969) and social interaction and integration (Weiss, 1969; Barrera, 1981) are salient features to a family environment conducive to health and well-being. To varying degrees, and not always well defined, each of these aspects of social support has been linked to health outcomes of particular life circumstances. Nuckolls and colleagues (1972) demonstrated the stress buffering effect of social support on complications of pregnancy; while Cochran and Brassard (1979) assessed the impact of parental social support and personal social networks on children's developmental processes. They found that developmental processes related to the network included direct cognitive and social stimulation, emotional and material support, access to opportunities for active participation in parents' networks, observational models of adults outside the home and sanctions for behavior. When the family is deprived of nurturance, feedback, enduring supportive relationships and protective health services; i.e. an impoverished environment, unhealthy outcomes and problems with person-environment fit may exist (Barrera, 1981).

Levin and Idler (1981) consider the **family as a mediating structure**, with instrumental and expressive functions. Its instrumental function is oriented to the larger society, as it provides information, influences judgment and perception

and facilitates tasks of its members beyond the family. Mediating structures, conceptualized as environments, help to explain how individuals are assisted, not only in making decisions, but also in carrying out the consequent actions.

> They (mediating structures) help interpret situations according to traditional, moral, religious, or other criteria and encourage individual action in harmony with the group's values and goals (Levin and Idler, 1981:28).

The family performs innumerable health-related tasks for itself. Its competence to protect, support and nurture its members is directly related to measurable levels of mental and physical health in individuals: a consequence of family environmental transactions (Speck and Attneave, 1973; Steinglass, 1981; Levin and Idler, 1981). The concept of family environment as mediating structure broadens the notion of family support beyond its expressive function to include its instrumental functions, the facilitation of decision-making and tasks in all areas of life.

Mediating structures may be viewed as health resources (Levin and Idler, 1981). They are the environment surrounding the individual and as such are a social resource for the provision of health care (Red Horse, Lewis, Feit and Decker, 1978). By giving stability to the private sphere of the individual and providing a variety of roles for the individual to fulfill, ethnic and self-identity are fostered which aleviate a sense of anomie. Further, the family as a mediating structure provides members with the cultural content and opportunity to express freely a set of values in a concrete, socially objective way. A sense of sharedness and effect in influencing social action is fostered as the family integrates the member into a community which

shares a similar view of the world. It provides family members with a historical perspective and group image.

Posser (1978) refers to the family as **cultural maximizers,** assuring survival and the passing down of traditions and values. It is called into service especially when conflict or dissonance occurs. The family environment's cultural component is transmitted for two purposes. First it provides the individual with a meaningful framework for living and making sense out of life and secondly, it preserves social ties and social structure of the individual (Levin and Idler, 1981). Ethnic identity is neither given nor innate. The way in which it is generated is always a psychosocial process, primarily within the family (Epstein, 1978). History provides people with a perception of their past, enabling them to be selective, stressing certain values to make positive identification with their ancestors and preparing them for a successful life. The capacity to redefine new situations in terms of established meanings and values, live in harmony with one's environment and express oneself in ways that win the approval of those who most immediately surround one are essential to holistic health and childbearing (Epstein, 1978). Support in the family network provides nourishment for self-esteem, normative affirmation, clarification of expectations, and discharge of disturbing effects (Kaplan, Cassell and Gore, 1979).

Research among Native peoples by Berry and colleagues (1982), Davies and Mayfield (1981) and Burke and Sawyer (1984) emphasizes an association between degree of parental ethnic identity and transmission of this to children and the well-being and growth of children. The ethnic identity

of both the individual and group is seen as important, as both are affected by, and affect, culture change (Mithun, 1983). Any culture change affects every facet of one's health and social life.

Epstein (1978) emphasizes the role of kin and family in the maintenance of ethnic identity over a number of generations, with the roots of development in childhood experiences. Ethnicity defines boundary maintenance and personal -environment transactions. Parents and grandparents play central roles in deciding how to **organize relationships** between extended **social environments** and children. In terms of the Native culture, adult members of the extended family assume this role within the tribal/band context (Red Horse, 1980). The family mediates environmental information to the child and other family members regarding current behavior, while communicating messages and restraints to eliminate discrepancies with the environmental norms of behavior (Levine, 1982). It is a pervasive agent for teaching the individual basic cultural patterns that will be required as fully participating members of the culture. This becomes particularly salient during maturational processes, such as childbearing, when new forms of behavior are required.

From each of these family perspectives, family childbearing values, beliefs, and practices can be examined. Women's experiences of childbearing have traditionally been family centered, with the process of childbearing and the birth event major social occasions in the home: occasions for extended family member involvement (Jordan, 1983; Levin and Idler, 1981; MacCormick, 1982). However, managing the events were usually the exclusive province of women: grand-

mothers, mothers, sisters, cousins, and aunts. All female relatives were role models and sources of information, knowledge, support and physical aid.

Supportive Family Functioning

Caplan (1976) suggested that successful fulfillment of the supportive, educative and mediating functions of the family depended on a significant level of intactness, stability, integration, and healthy interpersonal relationships in the family. This implies that the family environment may, to varying degrees, be supportive to individual health, but that a potential exists for it to be a source of stress if it is unable to function effectively. A typology developed for assessing family environments indicated that families differ in the various qualities and in the assistance they require to provide an environment that is supportive to its members (Moos and Moos, 1976). Moos and Moos (1976) report that a "conflict orientation" as measured by their family environment scale is associated with higher-drinking families, whereas "structure-oriented" and "moral/religious-oriented" families had a lower than expected proportion of high-drinking families. In two studies (Moos, Bromet, Tsu and Moos, 1979; Reynold, O'leary and Walker, 1982) that assessed family environments of treated alcoholics, a positive family milieu (more cohesion, less conflict and control) was associated with relatively greater improvement of the alcoholic family member. The results indicate that prior conceptualizations of family environments have been oversimplified by considering only the two dimensions of parental attitudes and level of control. Moos and Moos (1976) suggest three dimensions, each with subscales:

relationship, personal-growth and system-maintenance dimensions.

Cohesion, expressiveness and conflict are the subscales of the most important dimension to this study: the relationship dimension. Cohesion is the extent to which family members are concerned and committed to the family and the degree to which they are helpful and supportive to each other. Expressiveness is the extent to which family members are allowed and encouraged to act openly and to express their feelings directly. Conflict is the extent to which the open expression of anger and aggression and generally conflictual interactions are characteristic of the family. This dimension is important when the family is conceptualized as mediating between members and the larger society, as promoting the goal of a healthy person-environment fit and providing the supportive environment for development of the woman's self-concept and ethnic identity.

Self Concept

One of the most important integrating aspects of a woman's behavior is her self-concept. Epstein summarized the characteristics of self-concept after reviewing a variety of positions taken on the subject (1973). Of particular importance to this study are the following characteristics of the self-concept.

1. It contains different empirical selves. James (1910) and Allport (1961) consider the self as an object of knowledge which belongs to one's self. Knowledge about one's material self

(one's own body, family and possessions), social self (views others hold of the individual) and a spiritual self (one's emotions and desires) form the basis of the self concept.

2. It is a dynamic internal organization that develops with experience, particularly out of social interaction with significant others. Boundaries between the self and other individuals, groups and ideologies are determined by the self-concept (LeVine, 1982).

3. It assimilates increasing amounts of information.

4. When the organization of the self-concept is threatened, the individual experiences anxiety and attempts to defend herself against the threat. All aspects are capable of evoking feelings of heightened self-esteem and well-being, or lowered self-esteem and dissatisfaction. Problem-solving may be affected.

5. The self-concept has at least two basic functions. First, it organizes the data of experience, especially that involving social interaction. Second, the self-concept facilitates attempts to fulfill needs while avoiding disapproval and anxiety.

The woman's self-concept is a conceptual tool for accomplishing her purpose and facilitating the maintenance of her self-esteem. It organizes data of significant experi-

ences in a manner that can be coped with effectively (Epstein, 1983). According to Epstein, the self-concept is a self-theory which forms the basis of one's approach to problem- solving. Functioning as a member of society, the woman uses her selftheory to direct and monitor her behavior, and to determine the extent to which each of her behavior patterns is consistent with the image she holds of herself.

A self-theory addresses how an individual feels about herself in toto: physically, emotionally, intellectually, socially and spiritually. Jilek-Aall (1983), in her study of Coast Salish women, found that these women had a positive view of themselves in their daily lives and gained strength with their Indian identity and success with difficult past experiences. One of their most valued roles giving them self-esteem was that of mother. The self-theory reflects social norms such as those associated with the mother role. Normative social experiences with selection being made from among possible behaviors that are consistent with the socially acceptable image the individual wants/needs to present to the world contributes to the development of ones self-theory.

Development and Maintenance of a Self-theory

The family provides the immediate sociocultural environment for the woman to develop a self-theory. Feedback, particularly from parents and/or other significant adults, provides her with information about discrepancies between her current behavior and socio-cultural norms of behavior. Although parents act as agents of society for children and mediators of changing sociocultural norms, a prescriptive

self-theory can not be totally developed in early life. Future environments in adulthood may demand modifications of the previously learned beliefs, values and behaviors.

Although normatively influenced and shaped, self-theories are still highly variable in a population because they are embedded in different personality structures and genotypic capacities of social competence for approximating ideal role performance (LeVine, 1982). Maintenance of social competency which encourages an adaptive person-environment fit requires social feedback about one's behavior and its effects. In societies where there is little culture change and relatively stable social states, social competence may be reached without much feedback being required. The stability allows for, or tolerates, diversity of self-theories (LeVine, 1982). However, in groups exposed to consistent demands for cultural change, feedback is required on a continutal basis. When culture change is occurring amongst a group of people some new form of adaptation is required and individual internalized norms may no longer be adequate guides for socially approved behavior.

If, however, culture change is resisted and identity with the traditional or previous culture is strong, unity of the people is encouraged and development of more homogeneous self-theories is likely to result. Trimble (in press) found a relative homogeneity of attitudes toward the self among both reserve and non-reserve American Indians, all of whom perceived a consistently high degree of alienation from the larger social system. Like values and beliefs of the family and norms of society, experiences and perceptions help to shape one's self-concept. When a group of peoples is consistently treated in a persecutive stereo-

typic fashion by the dominant society into which assimilation is being imposed but resisted, the tendency to unite is strong and may result in members' development of more homogeneous self-theories (LeVine, 1982). Feedback from the larger society reinforces the unity of ethnic identity and self-concepts.

The Dynamic Self-Concept in Childbearing

Critical developmental and situational stages of the individual's and family's life cycle may affect one's self-concept to the extent that it is no longer congruent with the environmental norms. Childbearing and alcoholic drinking are examples of each of these stages. When they occur within a period of culture change and instability, dissonance among beliefs, values and practices may result in a maladaptive person environment fit. Feelings of anomie and alienation and suicidal and delinquent behavior are some current Native responses to dissonance.

Although childbearing is a biologically normal event, it is an exceptional one in the life of a woman and her family and as such requires a shift in the organization of values and roles. It is associated with a time of increased life change, as well as constituting a stressful experience itself (Wallace, 1977; Messick and Aguilera, 1976). Pregnancy requires that the woman, her family and significant others respond in ways appropriate to this critical maturational or developmental period. New coping mechanisms, acquisition of new knowledge and skills and modification of interpersonal relationships may be required as the woman's self-theory is reorganized. One's body image - shape, size, mass, structure, and function - is

dynamically changing and affects the holistic self-theory. Acceptance of "self-as-pregnant" by self and significant others is critical to the sorting out of one's self-identity (Ziegel and Cranley, 1984). Whether or not the childbearing experience will strengthen or weaken the woman's self-esteem and alter her self-theory/self-concept significantly depends upon the meaning of the event, expectations of self, family and culture, and the feedback received (Clark, 1979; Zeigel and Cranley, 1984).

Most reference texts state theoretically that a woman's self-concept changes with childbearing, especially with respect to her body image and her ability to function, but few references are made to research findings. Lee studied Black and Caucasian woman of low socio-economic status in the United States. She found that these woman, late in pregnancy, had lowered self-esteem (Lee, 1982). Depression and low self-concept were associated with infant outcomes of failure-to-thrive and child abuse.

Klinghoffer (1978) hypothesized that a woman's self-concept and use of alcohol during pregnancy would be associated with the level of stress experienced. There was no significant relationship between the level of life change, a measure of stress, and alcohol consumption. The results from this preliminary study suggest a significant inverse relationship between self-concept and number of drinks per occasion before pregnancy, but not during pregnancy. While most of the women in this study reported a decreased use of alcohol while pregnant, the self-concept was not measured prior to pregnancy. However, applying the self-theory to the childbearing experience, it could be argued that this experience, with feedback from significant others, enhanced

the woman's selfconcept, such that alcohol was no longer required for coping with a lack of person-environment fit. The drinking behavior also may have been altered to decrease potential dissonance among traditional values and beliefs and contemporary practices and teachings.

Many of the signs and symptoms a woman experiences during childbearing would, under other circumstances, indicate illness and one's self-concept would be expected to change from wellness and illness. When childbearing is considered normal and desirable, society expects the changes to be incorporated into the woman's self-concept of wellness. However, when changes in childbearing alter one's ability to carry out usual daily activities or maintain a body image, a psychosocial loss may be experienced and expressed in emotions such as frustration, anger, anxiety, fear, or depression. Rubin (1968) states "To lose or be threatened with the loss of a complex, coordinated, and controlled functional activity is to lose or be threatened with the loss of self" (Rubin, 1968: 22).

As well as being emotionally and socially aware of the impact of their childbearing experience, Jordon (1977) found that women were very aware of their bodies and its changes. Contrary to popular Western medical beliefs, the women were able to make a diagnosis of pregnancy earlier and with greater accuracy than was possible in the physician's office. Although her sample was from a feminist operated health centre, almost one half of the women knew of their pregnancy before they missed a period and at least 90% knew before the laboratory tests showed results. The material (body) self changes women reported in determining their childbearing state included five pregnancy indicators

consistent with the presumptive symptoms acknowledged by medical practitioners as being subjective and not valid for confirmation of pregnancy.

Although there is a paucity of empirically based research on childbearing women and their changing self-concept during pregnancy, the reported studies suggest that the self-theory in toto is of significance to understanding the emic perspective of the childbearing woman. No research related to childbearing Native women was found.

Alcohol and the Self-concept

The self-theory has also been useful in understanding the development and maintenance of alcoholic drinking (Bateson, 1971). Habitual assumptions one holds of oneself forms the self-theory that is used to make sense of, or determine, the relationship between self and environment. The assumptions govern adaptation to both the sociocultural and physical environment and become partially self-validating. Bateson (1971) found that "pride", a frequent characteristic of people who use alcohol excessively, was associated with an imbalance or dissonance in personenvironment transactions. The individual's self-theory was not contextually structured around past achievement, but rather oriented to proving oneself today. An obsessive acceptance of a challenge: "I can drink ..." is a repudiation of the proposition "I cannot". If sobriety is achieved, it is no longer an appropriate contextual setting for "pride" and self-esteem. The accomplishment is not a source of pride and the individual finds her self-theory to be inappropriate to maintaining a congruent person-environment fit. It is now the risk of the drink that is challenging. A

dissonance exists between her self-theory and the sociocultural expectations of the situation which may not be apparent to the individual without direct feedback from significant others in the sociocultural environment.

Using a similar framework for understanding drinking behavior, Forchuk (1984) analyzed the situation of cognitive dissonance related to treatment somewhat differently. While one must accept the fact that one is alcoholic, there is a concurrent need to accept the premise the "I am worthwhile". However, the premise of the alcoholic stereotype, which many have been incorporated into one's self-theory, assumes that the alcoholic is not worthwhile. Wallace (1977) found that shattered self-esteem and identity confusion are regularly occurring themes among alcoholics and problem drinkers. A dissonance in self-theory results because the two premises "I am alcoholic" and "I am worthwhile" cannot be incorporated together in the self-theory. The dissonance can only be resolved by the individual rejecting or altering one of the premises and functioning in an environment with social norms supportive of the changing self-theory.

Research findings supporting the concepts of dissonance and self-theory are based on numerous studies of white male alcoholics. It would be erroneous to generalize to the Native peoples, let alone to Native women. Problems with alcohol use among the Native peoples are influenced by unstable social norms, changing cultural value systems and resurgence of traditional Native beliefs, values and practices.

Self-theory among Native Peoples

Unfortunately, the Native self-concept is often presented in glossy negative terms, bolstered with social indicators portraying a profile of poverty, squalor, illiteracy and alcoholism. Continued promulgation of such outdated, unsubstantiated conclusions is inconsistent with findings of some recent studies.

Trimble (in press) reviewed research literature on personality and the self of the American Indians. The few studies that focused on the "self" as perceived by Indians indicated inconclusive research findings, while research emphasizing personality descriptions was obtained from controlled observations or use of personality instruments not validated for a Native population. Again the findings were inconclusive. No significant differences in self-concept were found between American Indian and white children in elementary schools in Nevada (Withycombe, 1970); whereas Coleman (1966) reported that Indian students' self-concept was significantly lower than white students.

Trimble's review of the studies in the 1970's indicates that the kind of school the Indian student attended was one factor in determining the self-concept (Trimble, in press). Students from segregated Bureau of Indian Affairs schools had scored significantly lower on the selfconcept scales than students from integrated public schools, and perceived themselves as significantly less accepted by their peers. Canadian researchers have suggested similar findings with Residential school experiences, although the studies were not specifically addressing the self-theory issue (Cruickshank, 1969; Castellano, 1975; Penner, 1983).

In an effort to assess the impact of an educational intervention program on self-concept, Mason (1969) studied American-Indian, Mexican-American and Caucasian subjects. She found that female participants demonstrated a more negative attitude in terms of personal worth and that the Indians tended to express the least sense of self-worth. It may be that the Native peoples, especially women, actually believed what was being said of them - "dirty", "drunken", "lazy", and "immoral".

Several other studies have reported a more positive orientation to the self. Fuchs and Havighurst (1972) reported "that self-esteem and self-concept data from our study indicate that the greater majority of Indian youths see themselves as fairly competent persons within their own social world" (Fuchs and Havighurst, 1972:147). A relationship between acculturation and self-esteem was found, such that acculturation led to increased stress and low self-esteem. The less acculturated Native peoples had a more integrated and stable personality (Trimble, in press). Trimble's study among 791 adult American Indians, representing 114 tribes living on and off reserves, found that the samples perceived themselves in a moderately positive way. The "high" self-perceivers felt significantly less alienated than "low" self-perceivers (Trimble, in press). In summary,

> ... we can conclude that those who hold 'good' to 'strong' opinions of themselves tend to have a more healthy outlook toward getting a great deal more positive feedback from others (Trimble, in press:29).

The research gap remains, however. Most of the personality and "self" research has been conducted on youth. Few

studies attempted to identify and describe self-concepts among adult or elderly Indians.

Although we have some general notion of the importance of children and the childbearing period to Native peoples, the problems experienced with alcohol and the resistance to assimilation, there is a paucity of information of how the Native woman views herself within this context and how this is associated with her lifestyle behaviors, including the consumption of alcohol. Do the Native childbearing women have self-theories that are similar to the Seattle Indian Health Board's perspective: "Self Image"? (Figure 4 - Self--Image)

Figure 4

Self-Image

I give myself the right to be who I choose to be. Some people may tell me I am not good. They may tell me I cannot do things well. I don't have to believe it.

I believe I am a human being with the free choices to see myself as important, valuable, talented, kind and needed. Or I can see myself as no good, lazy, mean and scarred. I am responsible for my self-image.

Life is a gift. I will not live feeling sorry for myself because I have not been as lucky as other kids. The world does not owe me anything. My life will be as good or as bad as I make it.

Before I make a decision to use alcohol or drugs, I will ask myself: Why am I taking this drug? What will I feel like tomorrow? Is there some better thing I could be doing? Am I taking it because I feel bad about myself? Am I drinking because others around me want me to? Would I do anything other

> people wanted me to? I am the only one who will answer for my actions.
>
> I am responsible for my self-image. I choose to treat myself with dignity. I will move toward love, knowledge and freedom knowing my life is what I make it.
>
> I AM AN INDIAN AND PROUD OF IT.
>
> (Seattle Indian Health Board)

Ethnic Identity

Epstein (1978) draws an association between the self-concept and ethnic identity. Where confusion and uncertainty threaten one's self-esteem and sense of one's own worthiness, there is likely to be a stronger identification with the ethnic group as it becomes an extension of the self, providing shared understandings, trust and appreciation. Positive ethnic identity is built on a positive self-concept, a sense of worthiness of one's own group's ways and values, which is manifested in one's attachment to them.

Definition and Dimensions

Ethnic identity refers to the way people categorize themselves in reference to others and attempt to associate or not associate themselves with persons whose spoken or silent language is similar to their own (Aamodt, 1978:9).

> Ethnicity in its narrowest sense is a feeling of continuity with the past, a feeling that is maintained as an essential part of one's self-definition....Ethnicity in its deepest psychological level is a sense of survival (DeVos, 1975: 17).

To adequately define ethnicity, one must assess the subjective aspect. This involves obtaining information on nationality, ability to communicate in one's native language, residence in an ethnically-defined neighbourhood and membership in ethnic organizations. In addition one must evaluate subject identification with, and attachment to, an ethnic group. These factors are crucial as they relate to ethnic self-concept and in turn to health status (Lorion, 1976).

Ethnic identity may vary in three dimensions: cultural content, historical experience, and group image (Spicer, 1972). **Cultural content** refers to the sensitivity one has to the behavioral differences of one's own people - e.g. standards, values, beliefs and practices. Values are guides and determinants of social attitudes and ideologies on the one hand and of social behavior on the other, and as such are critical to the determination of ethnic identity. A common form of **historical experience** is that of having designated reservations and being denied rights in association with these allocations. The dimension of **group image** incorporates the moral valuation of the group in relation to other groups and by other groups. Differences in time and nature value orientations between Natives and non-Natives have influenced the development of the stereotype "lazy" Indian. In a polyethnic situation, a sense of ethnic identity is always to some degree a product of the interaction of inner perception and outer response, of forces operating on the individual and group from within, and those impinging on them from without, including the stereotype approach (Epstein, 1978).

Epstein (1978) suggests three factors that contribute to fostering a sense of ethnic identity and continuity. First is a continuing attachment to the land since territory nearly always has great significance, positive or negative, for identity formation. Second, sharing of language or literacy heritage, religion, and a common history gives structure and substance to assumptions, values, and beliefs which underlie particular and varing expression for cultural behavior. Myths, various rituals and other activities which translate into social reality are the third variable contributing to ethnic identity and continuity. They find their expression in the "intimate culture" of the family: the home teaching of group ways, values and cultural norms.

Culture Change

Retaining ethnic identity has been of critical importance to the Native peoples during the past years of attempted forced assimilation. Culture change has occurred, but how the people, collectively or individually have viewed and dealt with it is not well understood. Berry and his colleagues (1982) conceptualized culture change among the Cree Indians as a process of adaptation. Four distinct patterns emerged: assimilation, integration, rejection, and marginality. These are similar to Miller's modes of adaptation: transitional, bicultural, traditonal, and marginal (Miller, 1979). Cultural content (especially language and home teaching of tribal ways) and group image (preference for marriage partner) were significant dimensions of ethnic identity in determining the pattern of adaptation. The dimension of historical experience may be important in cross-cultural studies, but did not identify individual

differences in a group sharing the same culture contact history.

Assimilation and integration are cultural changes in previous ways of life; learning new lifestyles but doing so selectively and sometimes in novel ways. They are relatively smooth processes compared to the rejection or marginality patterns of adaptation (Berry, Wintrob, Sindell & Mawhinney, 1982). These are generally disruptive for the group and stressful to the individual. The amount of stress experienced may depend upon the (1) adaptive pattern of acculturation chosen, (2) rapidity of change required, (3) cultural and psychological characteristics of the groups in contact, (4) incongruence between identity of goals and possibility of attainment, between aspirations and expectations, or between socio-political structures, and (5) discontinuity between cultures in lifestyles, values, beliefs and norms (Berry, Wintrob, Sindell & Mawhinney, 1982).

Culture change often requires an adjustment to dependence ushering in a state of paternalism. Epstein (1978) suggests that for those undergoing culture change, there are two consequences to paternalism. First, there is a feeling of powerlessness that they and their institutions are deemed to be without dignity or value. The powerful figures of the dominant culture must be propitiated, respected and obeyed. Second, paternalism gives rise to claims on the part of the dependents for whom it becomes a source of security. The dominant culture is seen as having assumed responsibility for protecting and providing for the needs of those adjusting to dependency. However, ethnic identity must also be understood from the perceptions of

the people, since it is always, in some degree, a product of the interaction of inner perceptions and outer responses and of forces operating from within and those impinging from without.

Burke and Sawyer (1984) found that the adaptive pattern of integration for the Native mother was predictive of the most healthy growth and development of the child. In Miller's study (1979) the hypothesis was supported that families which maintain a sense of Indian identity and are able to adopt strategies of urban living will make the best social and psychological adjustment to life in the city. This pattern of adaptation (i.e. biculturation, integration) demands that the Native person hold onto Native values and **means** and adapt to white **ends** without considering them primary value structures. Integration implies the maintenance of cultural integrity (i.e. standards, values, beliefs and practices) as well as the movement to become an integral part of a larger society framework (i.e. value orientations). When changes are forced, as in assimilation, value orientations may undergo more rapid change with a result that preferences among alternatives within the orientations are not marked or retained (Brink, 1984). People chosing the "marginal" pattern of adaptation often have the greatest difficulty in adjustment. They are considered to be anomic in both cultures.

Over generations, beliefs and values change very slowly. In an exploratory study of Native peoples (sample of 84 high school students drawn from a wide variety of tribal affiliations) Trimble (1976) found that despite their close interaction with non-Natives, integration was the pattern of culture change. A different value system was retained

somewhat intact, but at the same time the value system had probably undergone a change from tribal-specific values to a more generalized set of pan-Indian values. While the occurrence of ethnic pride and identity within a group can promote self-esteem and group cohesivenesses, the very element of this ethnic identity may also lead to certain negative outcomes that contribute to feelings of alienation, rejection and disrespect.

Health Implications

Smith (1971) and Horn (1975) report that Native Indian women have different belief systems and value orientations from that of the dominant society and health care professionals. However, the women find it difficult to maintain their own value systems while rejecting the other. They adhere to neither consistently. The two researchers draw independent, but similar conclusions: that ignoring these differences in the past has contributed to the maintenance of the high mortality rate and unacceptable health conditions on the reserves, as well as perpetuating the gap between prenatal services required by the Native childbearing women and those offered by the white middle-class health professionals.

Some real contrast in the traditions and expectations of Native and dominant cultures have been identified in the lifecycle transition period of puberty:

> ...at puberty almost all tribes had initiation ceremonies which marked the youngsters as men and women, able to take up responsible roles in the group....The contemporary complex technical economy makes it impossible for fourteen-year-olds to assume either the old roles of hunter and defending warrior or the new roles of wage

> earner and head of household. Comparable changes have occurred for girls and women (Attneave, 1979:241).

Many adults, particularly the grandparents, remember the traditional patterns and may scorn the young people, confirming their feelings of cultural conflict and cognitive dissonance. Women entering the childbearing years may be experiencing these inconsistencies at various levels in their environment: family, band and non-Native society. The cumulative impact of several generations of these inconsistencies, coupled with boarding school experience during the years eight to fourteen, have resulted, to some extent, in a loss of family and parental role models (Attneave, 1979) and changes in health-related behaviors.

An epidemiological study undertaken in a small, isolated fishing and lumbering village of the Pacific Northwest Coast revealed that the female and male adult population of the Indian tribe had significant psychiatric impairment from drinking (Shore, Kinzie, Hampson and Pattison, 1973). The one outstanding significant finding was that the segment of the population born outside the Indian village had a higher rating of psychiatric impairment than the Native reserve born (p.05). The authors conclude that exclusion from the mainstream, the effect of poverty, and cultural change might combine to produce increased morbidity. This was supported by the findings that the younger age groups of both sexes showed the highest rate of impairment, had the least knowledge of traditional Indian values, no longer spoke the Native language, and had the greatest ambivalence about living on their reserve. Their behavior patterns reflected an increasing contact with the non-Native culture. Levin and Idler (1981) concur that membership in groups who share an identity and a tradition

is protective against a wide range of minor and serious, even fatal illnesses, as well as suicide.

Role of Alcohol in Ethnic Identity

Of concern to the Native peoples of Canada has been the untoward effects that alcohol has had on their cultural content and group image. While alcohol has been of questionable social value to the Native peoples strengthening family and community bonds to some extent, it has led to their demise as it replaced other values in the heirarchy of orientations. Lemert (1958) suggested that drunkenness and abuse of alcohol took on a reactionary virtue for the Native peoples. The behavior became a means of resistance and discrediting the "missionary way" and at the same time a means of reaffirming older values. However, the pervasiveness and saliency of alcohol excluded opportunities for satisfying some values and allowed only a partial or compromised satisfaction of the others (Lemert, 1962).

> The values commonly sacrificed by drunkenness are respect for person, life, property, health, longevity, family integrity, parental responsibility, regularity of work, and financial dependability (Lemert, 1962:555).

Other values that suffered were individual decision-making with advice from elders (Bigart, 1972) and the importance of a guardian spirit in the time of crisis.

Value Orientations

Recognizing that Native peoples are different from non-Natives, one seeks to ascertain how certain values differ

so that ethnic identity can be understood. Unfortunately a complete catalogue of value differentials is not available due to the diversity among Native groups themselves. There are tribal and village differences, and a multitude of distinctions among the peoples depending upon the geocultural region where one is raised, the tribal language and degree of usage, the extent of intermarriage among one's family, the acceptance of traditional or contemporary lifestyle preferences, and the stereotypes developed (Trimble, 1976; Kekahbah and Woods, 1980).

Native values have been threatened or violated with culture change. Acculturation and assimilation de-emphasized equalitarian consensual rule and decentralized political power, ignored dignity and respect of elders and those in positions of authority and imposed a sense of urgency of time (Leon, 1968; McNickle, 1968). For the Native person there had always been time to get things accomplished, even if not completed today (Bryde, 1972). Promptness and keeping appointments were not high priority. Native people respected those with knowledge of the people and world around them. Their elders were respected for their wisdom as well as their knowledge. The individualistic orientation supported a permissive pattern of childbearing, not to be confused with neglect of children, but rather as the importance placed on personal independence over dominance. Positive encouragement and rewards were used instead of punishment to obtain desired behavior (Bigart, 1972). Common to hunting and fishing economies, values of self-reliance, individual antonomy and non-competitive achievement were important values in the socialization of children (Barry, Bacon and Child, 1959; Leon, 1968; Graves, 1967).

When community decisions were made, the problem was discussed until concensus was reached. No part was left in disagreement (Bigart, 1972). Manuel (1971), in his address to the First National Native Women's Conference said

> We discuss an issue or item on the agenda thoroughly. Sometimes we are far apart, and maybe in a day or two we finally reach a consensus - then a motion is passed and immediately voted on, and the whole thing is agreed upon. This is the parliamentary procedure we pursue in trying to reach objectives and goals so no one from the assembly goes away dissatisfied .

Some of the values that formed the basic Native orientation to solving human problems were: a spirit of brotherly love, a good sense of forgiving and sharing and giving (Cardinal, 1969). Generosity and sharing were valued above acquisitiveness and material achievements. The one who gave commands was the most respected (Bryde, 1972). Ownership of property was a privilege, not a right; if others wanted or needed it, social responsibility required giving it away (Bigart, 1972).

It is difficult to identify any single cultural belief or value as characteristic of Canadian Indians. Nevertheless, the following values seem to be inherent in all tribal groups even today: (1) respect for cultural diversity, (2) rejection of a competitive stance when it is for personal gain only, (3) acknowledgement of the interdependence of humans and the natural environment, (4) importance of tribal sharing, (5) use of intuitive as well as analytical thinking, (6) a spiritual outlook, which attributes a spiritual quality to all created things in the universe and (7) a sensitivity to other person, which includes preventing embarrassment or loss of face (Horn, 1982). The

degree to which these are evidenced in behavior has been found to vary with school experiences. Attending residential schools or staying in white boarding homes, both common past experiences of today's Native adult, exposed the children to a value system quite different from their Native family (Attneave, 1979). Table 1 contrasts the attitudes and values found between Native homes and white schools and homes.

Brink (1984) discussed Kluckhohn's four value orientations as they differed cross-culturally and how the concept could be used to identify dominant and variant values and beliefs that characterize groups and to establish possible areas of culture conflict in values for individual clients. Of particular saliency are the differences that were found between American Indians and Yankee Americans. It is reasonable to assume that similar directional discrepancies apply to Euro-Canadians and Canadian Indians, although the degree of saliency of the value orientations may differ slightly.

Within the Man-Nature Orientation, Yankee Americans emphasize mastery - over - nature. Man is expected to overcome the natural forces and harness them for a purpose. This is in direct contrast to most Native peoples' orientation which is one of harmony - with - nature. A sense of wholeness is based on a continued communion with nature and with the supernatural and a working within the laws of nature: not trying to change the world (Hungry Wolf, 1983; Bigart, 1972; Cardinal, 1969; Storm, 1972).

Table 1

Contrasting Values and Attitudes

Indian Home	White School and Home
Tribal loyalty	School, town team loyalaties
Respect for elders	Premium on youth and young adulthood
Reticence	Openness, verbosity
Humility	Competitiveness
Giving and sharing	Thriftiness, property acquisitiveness
Economy based on group sharing with extended family and wide range of relatives	Economy based on individual self-support
Roots permit exploration without breaking ties to people and places	New frontiers have high value while old ties may be felt as shackles
Attribution of human characteristics to animals and nature	Scientific objectivity
Strong spiritual beliefs; pantheism-monotheism, including unity of whole-world	Rationalistic attitudes, particularistic personal beliefs, usually monotheistic
Individual responsible to group	Individual responsible for self
Group decisions by consensus; internal conflict resolved or action not taken	Group decisions by majority, internal conflict continues and may provide lnew decision
Appeals to tradition as final authority and supported by spiritual beliefs	Appeals to power as final authority, supported by pragmatism, efficiency, sometimes abstract
Inborn characteristics unchangeable, growth in unfolding if innate trends	Malleability and changeability of human beings, especially children as they grow
Parents and elders provide opportunities for learning, discovery of capacities	Parents, teachers, peers shape outcome

Source: Attneave, C. The American Indian Child. In Joseph Noshpitz (Ed). The Basic Handbook of Child Psychiatry. New York: Basic Books Inc. 1979, 244.

In 1961 Kluckhohn and Strodtbeck found that Yankee Americans valued a future time orientation above that of the present and that the present was valued over the past. The past was accepted only as useful information, while the present was used to prepare for the future. However, perhaps their values are changing, as DeMay (1982) found that Americans had changed their time orientations to value the present over the future, which in turn was more salient than the past. The past is much valued by Native peoples, with emphasis placed on family and cultural traditions; using this to solve the problems of the present. Manuel (1971) states "...I think you have to look at the past before developing a constructive future. You have to relate the future with the past". The Native person lives in the present, guided by moment-to-moment relations with others (Bryde, 1972; Bigart, 1972).

The third value orientation to be compared was that dealing with the modality of human activity, which Kluckhohn and Strodtbeck (1961) described as being expressed in three alternatives of Being, Being- in-Becoming, and Doing. In the American core culture emphasis is on activity measured by standards conceived as external to the acting individual: the Doing activity which demands achievement through effort (Brink, 1984). Although this is important to the Native peoples, material achievement of acquiring many possessions for the purposes of social mobility is not. Their orientation includes Being-in-Becoming where emphasis is on the development of all aspects of the self as an integrated whole: physically, spiritually, emotionally and socially (Storm, 1972).

The last orientation is a concept of how human beings relate to one another. Americans, in general, value the individual alternative in the Relational Orientation. Individual goals are preferred to group goals; relations are built on individual autonomy; and reciprocal roles are based on recognition of the independence of interrelating members.

> The individual is not expected to be selfish or dictatorial, but rather (competitive) in goal-seeking behaviors and simultaneously self-directed and goal-oriented (Brink, 1984: 200).

In contrast, the Collateral orientation of the American Indians demands responsibility to group relations based on goals of laterally extended groups (e.g. family, band) and reciprocal roles based on a horizontal equalitarian dimension. The Indian learns to get along with others and values working with others. In the Native group there is conformity and cooperation, not competition.

It is sometimes assumed that these values are no longer salient to the Native peoples because of their behavior as observed by the non-Natives. Trimble (1976) cautions us from inferring the value from the role or role from the value because intrinsic value of any behavior is situational. Thus, Native values may reflect the ideal, but the behavior may suggest different intracultural dimensions depending upon the situation.

Reaffirmation of Ethnicity

Regardless of past experiences many Native people today take pride in their heritage and go to great lengths to

emphasize their ethnic and tribal background, such as wearing Native clothing and jewelry, learning the Native language and participating in Native customs and speech patterns. Isajiw (1979) considers these ethnic "rediscoverers" as persons from any consecutive ethnic generation who have been socialized into the culture of the general society but who develop a symbolic relation to the culture of their ancestors. While new religious forms are gaining strength and while more and more Native peoples are finding Christianity to be meaningful to them, there is an equally strong resurgence of old or modified tribal ways and values (Amoss, 1972; Gill, 1983; Jilek and Jilek-Aall, 1978; Patterson, 1962). Resurgence can be said to be first, survival and growth, and second increasing awareness among Indians of their own identity (Patterson, 1962). Gill (1983) refers to this contemporary process of reaffirmation of values as "traditional tenacity"; whereas Trottier (1981) considers this to be reassessment of the meaning of their identity as Indian. Turning to the strategy of pan Indian unification is a means of reducing the conflict between preservation and assimilation, between identifying with a close traditional group or with the larger white society.

Given that this reaffirmation of ethnic identity is to some degree observable among the Native peoples, it cannot be assumed that all traditional values have been accepted, nor that each individual or band emphasize the same value orientations. In measuring the strength of ethnic attachment, researchers have tended to focus on the extent to which particular customs continue to be or not be followed. There is the assumption that the persistence of customs (public culture) holds the key to persistence of identity.

Epstein (1978) refutes this by stating,

> ... what would seem to be important in the transmission of identity is not practice within itself, but the meaning that attaches to it, and the way it is connected ...many of the subtler expressions of ethnic behavior... are revealed in the ongoing life of the home, in the company of friends, or at ethnic gatherings, expressions of what I have called the 'intimate culture'... (Epstein, 1978: 111).

Such an orientation demands taking into account the interplay of the external environment and internal milieu, the objective and subjective, and the sociological and psychological elements as well.

Future Directions

The concept of ethnic identity may be helpful in placing primary emphasis on perception of the self, suggesting new perspectives for old dilemmas, and drawing attention to aspects of health concerns that hitherto have been overlooked (Epstein, 1978). It is assumed that the process of ethnic identity begins early in childhood experiences and socialization with the family (Epstein, 1978; LeVine, 1982; Keyes, 1981). A major source of ethnic identity is found in the cultural traditions related to crises in the life-cycle, such as coming of age, marriage, birth, divorce, illness or death (Keyes, 1981).

> The social networks "provide a meaning for many individuals through a chaining of relationships that gives a sense of identity and participation in a larger whole (Speck and Attneave, 1973: 11).

It is not surprising that most minority groups seeking to emerge as potent forces today refer to their family network

and tribal associations for identity. They have shared experiences and accumulated a history that have encompassed both formal group rules and roles and informal, random collections of people. Linkages between family and tribal networks enable the transmission of cultural information, the mobilization of support, and the development of a positive self-concept. Miller (1979) found in her study of four Native tribes that language retention and home teachings, as well as mother's stated preference for her child's marriage partner were important empirical ethnicity measures for the construction of family typologies. They have yet to be tested as predictors of healthy outcomes for growth and development, or childbearing.

One's self-concept and ethnic identity are inexplicably bound together. Is it possible that the predominantly positive patterns of self-concept previously discussed are a function of the heightened ethnic pride and awareness that have taken place among the Native peoples? If this is so, then the pattern of adaptation to culture change that would engender the least conflict and cognitive dissonance would be integration. This would allow for affiliation, maintenance of traditional ceremonies and opportunities for visiting among Native homes (Trimble, 1976). Not only would this require non-Natives to have an understanding and respect of Native values and value orientations used to solve potential or actual health problems throughout the life cycle; it would require the involvement of Native peoples in administering those solutions in a culturally relevant manner and providing them with the opportunity to govern their own affairs.

Consistent with Native peoples' value orientations, Jilek and Jilek-Aall (1978) and Speck and Attneave (1973) urge clinicians to focus on family dynamics and involvement that mobilizes friends and relatives into a social force which serves to counteract conflict and cognitive dissonance. Depersonalization and isolation can be decreased with the use of traditional patterns of communication and health caregivers (e.g. Shaman) by clarifying Native perspectives and orientations (Jilek and Jilek-Aall, 1978; Jilek, 1974; 1977; Jilek-Aall, 1976; Trimble, 1976). Knowledge of the strength of value convictions can be useful in providing culturally-relevant health care.

Because of value orientation differences, approaches to solutions of human problems have not been successful. Trimble's (1976) account of misunderstanding between the clinical staff and the Navajo "patient" is a graphic example of an inappropriate solution to a misdiagnosed problem; while at the society level, differences in value orientations have resulted in serious environmental and land development problems, pollution and erosion (Berger, 1980; Berry, Wintrob, Sindell and MaWhinney, 1982; Chance, 1965; Cardinal, 1969). Perhaps Speck and Attneave's concept of retribalization - a way of restoring a vital element of relationship and pattern that has been lost, when skillfully "harnessed and channelled" would revive or create a healthy social matrix which then deals with the distress and the predicaments of its members more efficiently, quickly and enduringly than any outside professional can hope to do (Speck and Attneave, 1983).

Nurses, as culturally-sensitive caregivers, could assist Native women examine the existing relationship between

values, the lifestyle required for a healthy childbearing outcome and ways to bring these values into perspective. Strength of value preferences are important in shaping the way Indians perceive themselves and how they relate to others. There is the need for nurses to concentrate on value preferences and ethnic identity rather than preconceived images or notions about Native peoples.

Cultural beliefs and values about pregnancy and differences between behavioral expectations of health personnel and of self will affect the woman's motivation to seek prenatal care. There is a potential for conflict and cognitive dissonance as Native people attempt to internalize alien values and accept health services by non-Native caregivers. Conflicts result when there is a lack of understanding, communication and respect between the two parties. If the conflict is unresolved there is a danger that the woman's personal feelings of morality and competence, both required for maintenance and enhancement of self-esteem, will be affected (Rokeach, 1973). This in turn will affect her health-related behaviors and health status.

Health: Values, Beliefs, and Behavior

Health beliefs and practices related to maintaining health throughout the life cycle and curing sickness are part of the culture of all groups. They relate to a group's world view, symbolic meaning, values and learned patterns of social conduct that together constitute the essence of a group's life: its ethnic identity. Responses to particular aspects of one's life (health, sickness, childbearing etc.) and to the environment in which transactions occur

(physical, political, social, cultural etc.) are reflected in health beliefs and practices.

Chrisman and Kleinman (1983) stress that from an anthropological and cross-cultural perspective a number of general predictions can be made regarding generic health-related behaviors. 1) Self-care with assistance from family and friends is the norm; whereas professional care is the exception. 2) Social networks provide more lay treatment than lay referral, thus keeping health care guidance within socially compatible boundaries. Therefore, the environment of the family and the characteristics of the transactions among members will influence the amount and type of self-care and lay treatment and when and how entry is made into the folk and professional health care sectors. 3) Not all beliefs and practices are adaptive to optimal well-being. Often they consist of routine, unexamined, principles and activities that constitute strategies which are intended to effectively manage life problems, but when examined, conflict is noted between self and others. Both lay people and practitioners base interpretation of symptoms and care on psychological, social and cultural orientations. Each participant comes with a particular analysis of the health concern, potentiating an opportunity for incongruency and misunderstanding. 4) Lastly, one can expect that cultural idioms and metaphors will be used to relate everyday reality with the health-related event. The cultural component of the communication medium, as well as messages, is in some ways specific to each socio-cultural group. How health problems or concerns are communicated, the manner in which the symptoms are presented, when and to whom, how long one remains in care, and how that care is evaluated

are all affected by cultural beliefs (Kleinman, Eisenberg & Good, 1978).

It is appropriate, if not critical, to determine the important foci of health beliefs, values, and practices which might form the bases for misinterpretations and misunderstandings during the childbearing period. Also, the study of childbearing is one way in which concepts of sickness and wellness, disease and health might be more clearly understood (Kitzinger, 1982), as related behaviors are studied within the context of the individual's normal life cycle.

Three distinct, but empirically interrelated concepts are salient to the framework of this study: explanatory models, health care sectors and health-seeking process. A fundamental distinction exists between client views, i.e. of sickness as illness, pregnancy as normal, and biomedical views, i.e. of sickness as disease and pregnancy as irregular (Eisenberg, 1977). Although research related to these concepts has focussed on sickness, rather than health and well-being, some parallels can be drawn with the childbearing process. Pregnancy and birth may be perceived as having degrees of regularity or irregularity, and as a natural transitional or medical crisis event in the life cycle (Horn, 1975; Bushnell, 1981; Jordon, 1983). Interpretations of the event, expectations of behavior and outcomes, and advice given and taken will vary depending upon one's perspective. Nurses and other health care professionals have generally used a biomedical model to understand health and childbearing, while client groups with varying social and ethnic backgrounds have used others. Within the biomedical model, a technological

orientation is taken to reach goals of gaining control over the crisis potential of childbearing processes, eliminating pain, and reducing mortality (Kitzinger, 1982). From a non-professional, holistic perspective, childbearing may be considered a time to be in harmony with the environment, potentiating the naturalness of a transitional process. The health profesional's biomedical model leads her to identify problems of patient noncompliance and underutilization of professional health care resources; whereas from the perspective of the client, the reason for underutilization may be dissatisfaction with the impersonal clinic ambience, the dehumanizing encounter with the caretakers (McClain, 1982), and lack of attention to cultural imperatives.

Explanatory Models

To understand the meaning of childbearing and health it is necessary to look at explanations about the dynamic interactions between physiology, society and culture: an approach already taken with illness episodes. How people perceive, experience and cope with illness have been found to based on their explanations of sickness/wellness (Kleinman, Eisenberg & Good, 1978). It is the construction and communication of this explanation that is considered an explanatory model. Kleinman (1980) defines explanatory models as explanations, directed at specific episodes of sickness which label, classify, interpret illness, and establish the grounds for choosing between alternative forms of therapy. Major discrepancies may occur among the explanatory models of individuals, families and practitioners.

To date, the concept of explanatory models has been applied mostly to studies of illness behavior and utilization of medical services in pluralistic cultural contexts. McClain (1982) concludes from her review of cross-cultural childbearing studies that this concept is also appropriate to the analysis of practitioner-client interaction and behavour in maternity care. Jordon (1977) found that women's understanding of pregnancy, knowledge of symptoms and previous experiences influenced their involvement and adherence to professional health care. Explanatory models of childbearing have been shown to influence women's expectations and perceptions of symptoms and events that will occur during the period. The way in which particular labels (such as "at risk") are attached and the valuations and responses that flow from those labels are outcomes of explanatory models (Waxler, 1974; Jordon, 1977; Scarletta, 1984). Explanatory models of illness have been shown to guide choices among available resources, give personal and social meaning to the experience, answer questions related to knowledge of cause of pregnancy and identify sources of anxiety and support. However, there is a paucity of research related to explanatory models of childbearing.

Some ethnographic, descriptive literature describes Native Indians' perspective of childbearing as being a normal part of the life cycle and an opportunity to demonstrate one's belief in the value of children regardless of family relationships. It is the childbearing woman's responsibility to interpret her symptoms as defining the regularity of pregnancy. These explanations provide the basis for understanding the Native people's view of self and family care, traditional beliefs and practices, and late episodic involvement with professional medical (health) care during

the childbearing period (Bushnell, 1981; Loughlin, 1969; Horn, 1975). Traditionally, life cycle crises (e.g. puberty, childbirth) were governed by numerous disciplines; ritually correct behavour was desired and practiced and supernatural edicts governed the natural (Gunn, 1966). Achieving and maintaining health and wellness were the objectives of such explanations.

Three theories of disease prevailed among the Native peoples of the Northwest Coast (Gunn, 1966). The two principal theories of pathogenesis were disease by intrusion of foreign bodies and disease by soul loss. A third, less prevalent belief, was that described as spirit sickness. Shamen were the medical specialists at the time of illness, acting as the intermediaries between the individual and supernatural world, while simple remedies were relegated to lay practitioners (Gunn, 1966). How these theories of disease relate to explanatory models of childbearing and guide behavior during the experience is unknown. It is known however, that Shamen and midwives were involved in providing assistance in both regular and irregular childbearing situations (Hungry Wolf, 1982; Neithammer, 1977; Terrell & Terrell, 1976; Bushnell, 1981)

Health Care Sectors

The health care system can be viewed as comprising three overlapping sectors: professional, folk and popular (Chrisman, 1981). The participants and their practices comprising each sector depend on current cultural beliefs and social values. Interaction occurs between the sectors of care with exchanges of knowledge and technical resources and sharing of beliefs and practices.

Within the **popular sector** the family is predominant. It provides almost exclusive treatment to common health concerns. Self-care, as well as the covercare received from members of social networks, is distributive and community based in the popular sector. Chrisman and Kleinman (1983) state that

> ...several decades of research now make it clear that in many societies most health maintenance and care are delivered in and by the popular sector (570).

This has the distinct advantage of having illness labeling and treatment come from the same belief system, which helps to prevent misunderstandings. Popular treatment includes 1) a variety of remedies, such as diet, special foods, herbs, exercise, baths, massage and rest, 2) support and caring from members of one's social network, and 3) symbolic therapies, such as prayer, religious rituals, and secular prescriptions. Traditionally these sources and types of treatment have been important to the Native childbearing woman (McClain, 1982).

The **folk sector** includes nonprofessional specialist care that incorporates elements from both the popular and professional health care sectors. Shamen, midwives and birth attendants have been important folk practitioners, especially at the time of birth (Jordon, 1983; Bushnell, 1981). For regular childbearing experiences, the midwife and/or birth attendants were engaged at the time of labor. Should there be some serious irregularity of the process the Shaman might be called in because of his great spirit

power. However, there was little formal involvement of the folk sector during the prenatal period.

The **professional sector** of care includes health service professionals and bureaucrats whose clinical practice is complex, highly developed, and episodic (Chrisman & Kleinman, 1983). The explanatory model underlying the practices is usually a scientific, biomedical one, quite different from the Native explanatory model.

It is unlikely that childbearing women use one sector exclusive of the others, or are only involved with one sector at a time. More likely they use more than one at certain times and choose combinations based on their cultural values and beliefs, if behavior during the childbearing period follows the pattern of illness behavior.

Health Seeking Process

The third model influencing the discussion of health-related behaviors in childbearing is the health-seeking process. Chrisman (1977) conceptualizes this process as being comprised of five interrelated elements: symptom definition, treatment action, adherence, lay consultation and referral and role shift or modification. There is no one fixed sequence to these elements and several may be skipped or recur during an illness episode. The model is a holistic approach to conceptualizing people's experiences with sickness as natural histories of illness, as it describes the complexity of events that take place when a person is sick (Chrisman, 1977).

Although not generally considered a sickness, pregnancy and birth are considered by health professionals as requiring a health-seeking process. Understanding the conceptual elements of the health-seeking process in childbearing should increase the capacity to link sociocultural factors such as health beliefs or role expectations to behaviors during childbearing.

A preliminary study of the values and needs as perceived by North American Indian women in relation to prenatal care reported that pregnancy was considered a normal expectation in the life cycle, requiring normal activities, as well as an awareness of forces that could disrupt harmony (Smith, 1971). Pregnancy was defined as a natural condition, therefore it only required common sense, not a lot of external or special considerations. Lay consultation included family, particularly grandmothers, and friends who were respected, trusted and understanding. Although there was no illness related shift in role behavior, rules, and disciplines specific to childbearing required attention. Red Horse (1980) states that spirituality and family linkages strongly influence the definition of somatic and mental health especially during periods of transition such as childbearing.

Cross-cultural studies of every day health behaviors have indicated ethnic differences in patterns of health-seeking (MacCormick, 1982; Cosminsky, 1982; Lovell, 1983; Spector, 1979; Lin, Tardiff, Donetz & Garesky, 1978). Studies including Native Indians have reported: 1) infrequent and late contact with the professional sector, 2) symptom definition related to spiritual or supernatural world, to an imbalance with the environment (physical and social) or

to painful discomfort, and 3) heavy reliance on lay consultation and referral, particularly the extended family (Spector, 1979; Lin et al, 1978; Liverman & Frank, 1981; Young, 1982).

Two different sudies of health-related behavior of Native peoples living in Vancouver, British Columbia found that : 1) they relied almost exclusively on popular and folk care, 2) there was a close association between health and socio-legal lifestyle behaviors, and 3) great discrepancies existed between expectations and health beliefs of the popular and professional care sectors (Mears, et al 1981; Lin et al, 1978). When compared to other ethnic groups, the Native peoples living on skid row 1) had increased alcohol or drug, social and suicidal problems, 2) were more likely to have their problems recognized and referred by social service or legal agents rather than by self, family or health professionals, and 3) experienced the least positive treatment effects when health professionals recognized the problems and psychiatric facilities were involved. More positive results were obtained when the family or social services recognized the problem and/or were involved in treatment. However, in general, the Native peoples in these studies had no supportive socio-cultural network and no available culturally-appropriate folk care sector (Lin et al, 1978). This was also found by Walker (1978) with Native women in a Seattle alcohol treatment centre. Both studies involved Native peoples living off the reserve. Research in health seeking behavior of Native peoples living on the reserve has not been reported.

Many sociocultural influences affect the health-seeking process. Spector (1979) and Lin and colleagues (1978) concluded that external factors were strong determinants of the health-seeking process of different ethnic groups. In general, poverty, accessibility, verbal and non-verbal communication, deterioration of individuals within the confines of the family and institutional issues of control, prejudice, depersonalization and coordination of care were considered barriers to involvement with the professional health care sector.

The Native Perspective

Martin writes from personal knowledge of issues important to contemporary Native health beliefs, values and practices (Martin, 1981). Many of these issues influence the health-seeking process of Native peoples.

1. Well-being is based on a harmony or equilibrium of forces, including the social and psychological. Therefore, responsibility for well-being, although shared, is primarily that of the individual.

2. Healer and patient share a system of beliefs about the nature of the world and the nature of disease. The folk sector is thus seen as the sector most congruent with one's beliefs and values.

3. The patient's sickness places a responsibility on patient and family to participate in healing rites. Active participation in health care is critical to success in healing.

4. The healer involves the patient, family and others. The patient is treated within his social support system so that familiar and congruent elements can enhance the healing process.

5. The healer focuses on illness rather then on disease, i.e. his attention is on the reaction of patient, family and others to disease, rather than just on the disease.

6. The healer enlists participation of others via ceremonies, rituals, songs, and dances.

7. The helpers assess the patient's belief in the healer and provide feedback to both, as trust and belief are essential conditions for the healer's activities to be successful.

8. The helpers welcome the patient, give him time, listen, answer questions and explain, before and after the ceremony. Knowledge and information are important to the patient's response in the healing process.

An understanding of the Native perspective on childbearing with its associated beliefs, values and behaviors, could be conceptualized by using a framework that includes the concepts of explanatory models, health care sectors and health-seeking process. An appreciation of Native peoples' health-related behavior is critical to determining culturally-sensitive nursing care to promote and maintain well-being and health. Knowledge of how beliefs, values and practices are transmitted between generations and cultures and what happens when discrepancies occur will

increase nurses' understanding of Native women's health behavior in the childbearing period.

Theories of Communication, Learning and Cognitive Dissonance

A sociocultural perspective has been a basis for studies of health and health care behavior in the past. It is based on the premises that socialization and enculturation of individuals into specific societies involves learning of the values, norms and role behaviors; and that the social and cultural group is the milieu in which human interaction occurs and health beliefs, values and practices are transmitted. In childbearing, as in other areas of health, fears, taboos, and superstitions are frequently combined with factual knowledge (Snow, Johnson & Mayhew, 1978). This combination provides a powerful force for determining behavior. Among the Native peoples, variations in communication and learning will influence the direction of this force and subsequent health-related behavior.

Symbolic Interactionism

Blumer's interpretation of symbolic interactionism is a useful perspective to take in understanding cultural communication, learning, and behavior (Blumer, 1969). Three premises comprise the nature of the concept.

1. Human beings act towards things on the basis of the meanings that the things have for them.

2. The meaning of such things is derived from, or arises out of, social interaction that one has

with one's fellows.

3. These meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things encountered (Blumer, 1969).

Humans learn through basic symbols and interactions with others developing conceptions of self and definitions of social objects. The family environment provides the primary socio-cultural arena and players for this to happen. Both a person-environment interaction and an inner process interpretation are required for learning. Interpretation becomes a matter of handling meaning. It is formed in and through the defining activities of people as they interact (Blumer, 1969). Meanings are used and revised to give guidance for both symbolic and observable behavior (Denzin, 1978).

Thus, to understand behavior, it is necessary to obtain an emic perspective and to recognize how personal and social interactions in the communication process influence perception of meaning. Denzin (1978) proposes an ordering of concepts so that a distinction is attained between the researcher's conceptions of the subject's behavior and the motives and definitions that subjects ascribe to their own conduct. First order of concepts are those of empirical reality: of everyday life. Second order concepts are abstract and theoretical in nature. Researchers must learn everyday conceptions of reality, as well as interpret that reality from the stance of sociological and cultural theory.

A symbolic interaction approach is appropriate for the purposes of this descriptive, ethnographic study. Both Becker (1974) and Moos (1979) used this perspective in developing and testing their theories for predicting health behaviors. Steinglass (1979) used the premises to structure a successful family theory program for alcoholics. Closely related to symbolic interactionism is Epstein's "self-theory" (1973) and Cobb's definition of social support (1976). Family theorists have used the approach to interpret intergenerational transmission by stating that younger generations tend to learn the style of life from older generations, unless something happens in the society to change the values, definitions, meanings or learning opportunities in culture (Burr, Leigh, Day & Constantine, 1979). Social factors influence variation in intergenerational transmission and have an impact on beliefs, values, definitions and perceptions held by the individual and communicated by others.

Communication

Cultural traditions, norms and values are constantly being created, shaped and passed on to others through the ongoing process of communication and social discourse. Prosser (1978) contends that we communicate both unconsciously and deliberately when we seek to influence the beliefs, attitudes, values and behaviors of others. Communication and culture are so closely bound together that virtually all human social interaction is culturally linked. Individuals are selective in the content, as well as the style, of communication, factors which are usually culturally and socially determined. Effective cultural dialogue results from the ability to get in touch with one

another: by learning to know and feel what others know and feel. What is communicated and what is received may differ however, and any analysis of the learning process and behavior must include both perspectives.

Holy (1976) claims that people express their knowledge of cultural and social reality by displaying behavior that is in accordance with their knowledge and by making statements about it. By claiming ignorance of particular aspects of life (e.g. sacred or sensitive issues), the individual can define the situation of social interaction and treat the relationship within personally, socially or culturally acceptable boundaries. The fact that different knowledge is applicable to different situations permits the empirical existence of a seemingly paradoxical state of affairs when people manage to negotiate unproblematically their everyday interactions while holding simultaneously knowledge that is obviously contradictory (Holy, 1976). Socially available knowledge is not a perfectly integrated system; there are many instances of contradictory knowledge being held. This may be evidenced in the childbearing period when traditional and contemporary beliefs, norms and explanations differ.

Moreover, the total stock of knowledge available to any individual is different, due to the unique character of her biography and from the knowledge available to any other member of her society. The knowledge every individual possesses is determined by her position in the society in two ways (Holy, 1976). Due to one's specific social position, one has access to certain knowledge. Native families holding a certain status within the tribe, have access to privileged knowledge. Individuals with certain

characteristics and powers deemed to be worthy of learning the ways of the Shaman or midwife are instructed in private, privileged knowledge and practices (Morgan, 1981; Lurie, 1972; Benedict, 1934). The corollary of this social determination of each individual's stock of knowledge is the process whereby, claiming a certain knowledge or the lack of it, an individual manipulates her social position. By claiming or disclaiming knowledge adequate for her position, she either sustains its previous definition or changes it. During the spirit quest, the young Native supposedly receives not only power, but a vision, song and dance. To ratify the results of her successful quest, and new position, she must demonstrate this newly acquired knowledge to tribal witnesses. This study takes the approach that understanding the relationships among communication, knowledge and behavior is critical to discovering both the public and private knowledge held by Native peoples surrounding the health-related beliefs, values and behaviors of childbearing. How both types of knowledge are communicated and learned must be determined.

Learning

Learning, one of the basic activities of life, may be considered an adaptive mechanism to one's cultural environment. People reared in different cultures learn to learn differently (Hall, 1973). Some do so by memory and role modelling without reference to "logic" as we think it; while some learn by demonstration but without the teacher requiring the student to do anything herself while "learning". Learning assumes a vital role in culture transmission.

A theory of learning consistent with the perspective of

cultural holism is the cognitive field theory (Bevis, 1978). Its salient feature is the premise that a simultaneous mutual interaction occurs between the unit "women-in-environment". Cognitive field theory deals with the concept of person within the whole field: the total environment. Kurt Lewin (1942), a major proponent and classic developer of cognitive field theory, states that nothing exists in and of itself to people: it exists as relative to a person's total experience. Reality for any women is what she perceives and experiences it to be for herself.

Cognitive field theory maintains that learning is a matter of understanding relationships within a total "field" or area. A thing is what it is because it exists in relationship to other things. The theory of learning defines perceptions as all the different ways one becomes familiar with one's environment, not just a consciousness of it. Things and people are perceived differently by different individuals because their perception depends on the sum total of their life experiences and on how they perceive other things in their life space concomitantly. Learning takes place when data are consonant, or "add up", when all pertinent facts are taken onto consideration and when insight is achieved (Bevis, 1978). One would expect then to see behavior that is congruent with newly acquired knowledge and when learning has occurred (Holy, 1976). The concepts of wholeness and "self" as emerging, becoming, always in the making are fundamental to the cognitive field theory of learning: a theory which provides direction for analyzing knowledge transmission and interrelationships between the woman and her environment. The theory builds on both emic and ethic perspectives, recognizes the selectiveness of learning and conceptualizes learning as a transactional process requiring consonance.

Theory of Cognitive Dissonance

Cultural, social and personal pressures are continually manifested in the transactional processes of communication and learning. They are important sources of dissonance and disjunction. Disjunction between the personal goals of the individual and the sociocultural means for their legitimate attainment is often a source of dissonance (Graves, 1967). For example, culture change or adjustment of person-environment fit may create disjunction between a new goal system and inadequate economic and social access. Most of the research among Native Indians that uses a cognitive dissonance framework relates to the use of alcohol.

Lurie's work with Native Americans revealed a situation whereby Indians wanted to persist and succeed on their own terms, while at the same time borrow freely from the material aspects of white culture (Lurie, 1972). She found that Indian drinking was an established means of asserting and validating Indianness in direct proportion to the availability of other effective means of validating Indianness. Ethnic identity seemed to be an underlying factor in this dissonant situation.

McClelland and colleagues in their cross-cultural study of folktale content and drinking concluded that societies which do not provide strong support and stress inhibition and respect, put an individual in a conflict situation in which she wants, or is expected, to be assertive and yet must be obedient (McCelland, Wahner & Kolin, 1966). The person's self-concept is threatened. The individual responds by dreaming of solving the conflict by being powerful in a primitive, non-instrumental, impulsive way and finds alcohol a means of promoting these dreams: of buying at least temporarily the strength she needs.

Each of these studies has approached discrepancy in perceptions and behaviors of individuals and groups as dysfunctional dilemmas. Festinger's theory of cognitive dissonance seems to be particularly pertinent to the analyses of these situations (Festinger, 1957). The theory alleges that if a person's cognitions (knowledge, opinions or beliefs) are inconsistent with one another, that person will be uncomfortable and will be motivated to make them more consistent. The person will attempt to perceive or evaluate the various aspects of herself, environment and transactions between the two in such a way that the behaviors and implications of her perceptions will not be contradictory. Individuals will attempt to act within their belief system rather than behave in a way which produces dissonance within their cognitive framework or explanatory model. Reduction of dissonance may be accomplished by rejecting or altering one of the conflicting cognitions, denying the behavioral outcome associated with the dissonance or finding a new behavior (Forchuk, 1984). Festinger (1957) states that resistance to changing one's cognitive elements is determined by the amount of new dissonance that might be affected by the change.

For the purposes of this study, the theory of cognitive dissonance is relevant to understanding the relationship of traditional and contemporary beliefs and practices in childbearing and exploring areas in the cultural systems where dissonance might occur, or is occurring. Consideration of lifestyle behaviors, such as drinking alcohol, with Native beliefs of family cohesion, values related to healthy children and the process of culture change demand a recognition of individual and group dilemmas before suggesting ways to increase the consonance from a nursing perspective.

CHAPTER III
STUDY DESIGN - FIELD WORK

Approach

Childbearing is as much a social and cultural phenomenon as it is a biological one. Research into cultural aspects of childbearing is still in its infancy even though it is generally agreed that knowledge of the women's lifestyle, beliefs and behaviors can enhance nursing judgments, decision making and theory development (Jordon, 1983; Leininger, 1978). Childbearing behaviors, like other human activities, occur within a total cultural context, no part of which is entirely independent of other parts (Berreman, 1966). In addition social, political and economic factors influence health status. For culturally relevant nursing theory to be developed and care implemented, it is the investigator's position that the knowledge and theory base of nursing needs to be expanded by research which specifically aims to investigate the cultural context and family environment associated with the childbearing phenomenon of the Canadian Native peoples. Ethnography is a research approach particularly suited to the purposes of this study.

Ethnography can be defined as the descriptive analysis of a culture (Gittenberg, 1981). The epistomology upon which this ethnographic study was based included both emic and etic approaches as well as an emphasis on conducting the research in the natural setting. The underlying premises to this integrated approach to research were: 1) knowledge is acquired through an understanding of the meaning of behavior according to the perceptions and interpretations

of those involved in doing or supporting the behavior; 2) the meaning of the women's behavior can be interpreted and explained by the investigator in her own nursing theoretical dimensions as well; and 3) human behavior can only be understood within the context in which it occurs.

Stages of Study

Entry

This study of Coast Salish childbearing practices developed in three stages. The first, most difficult and lengthy stage was the initial entry into the cultural milieu: establishing trusting relationships with Native leaders and health care workers and determining the most appropriate methodologies for the study. True to Cardinal's observations

> Years are required before non-Indians can build up a relationship of trust and confidence between themselves and local Indian communities. Regrettable or not, this distrust is a fact, and it plays a negative role when a white tries to get something started in an Indian community (Cardinal, 1969:93).

For approximately two years prior to embarking on the actual research, the investigator attempted to prepare herself and the environment. Various types of professional volunteer activities were carried out in a number of Native communities and settings, including nursing assessments in alcohol treatment centers, consulting to Native health committees, attending Native Alcohol and Drug Program Conferences and acting as vice-president on the board of a Native Health Society that was writing proposals for clinic

funding. Combining urban and rural, non-reserve and reserve locations as contexts for these activities further broadened the investigator's knowledge of Native peoples' way of living, as well as giving her a sense of the similarities and differences encountered in health and childbearing concerns. Gaining entry into these settings was relatively easy because there was a contribution or service associated with the relationship and the Native peoples recognized that they might benefit from the input. Establishment of trust came with showing respect and a willingness to learn, being non-judgemental in listening to their meanings, aspirations and plans and contibuting when invited to do so. At this time it was also possible for the investigator to explore appropriate and meaningful approaches to scientific inquiry. Both direct and indirect consultation processes were used with the Native peoples to determine a general orientation to the subject of childbearing teachings and some specific means of obtaining data. Their interest, suggestions and willingness to provide introductions was indeed most valuable.

Stage 1 of the research migh be likened to a preceptorship where the investigator conscientiously and assiduously looks for culture brokers or mentors who will not only give advice and guidance, but also critique one's approach, purpose and methodology. In this study Native leaders and health care workers were considered suitable mentors. Their feedback on the the purpose and design of the research and willingness to participate in interviews was critical to the development of guidelines for culturally-sensitive interviews (Appendix A) and subsequent success of the study. It was through the support and interest of a Community Health Representative (CHR) and Native Drug and

Alcohol Program Consultant that advancement to Stage 2 was possible.

Reserve Contact

Stage 2 involved getting permission from the Band Chief and Council to engage in the study on the reserve and then by the women and their families to participate in interviews. Respect and understanding for the Native peoples' hesitancy in engaging in research was required. The investigator was repeatedly reminded that previous research had not resulted in demonstrable benefits for the Band or families; rather the contrary, where there was a feeling of having lost some of their culture by sharing it and not having control over the ways in which the data was used or interpreted. It is fair to say that many of the Native leaders have a degree of animosity towards researchers and research, unless it is done by their own people, or at their request. The relevancy and benefits of the research must be clear to the Native peoples, and the people should be given the opportunity of deciding the extent to which the information can be disseminated (Efrat & Mitchell, 1974).

Contact with the Band Chief and Council over several months of discussions of content, process and intent of study resulted in permission, but not facilitation, to work on the reserve. The proviso was that the CHR or other Band member act as mediator between the investigator and the woman and her family, and the participation be clearly described and understood as voluntary. An information sheet was used to discuss this with the women and her family (Appendix B). Oral consent to participate formally in the study was determined to be culturally appropriate by

Band members. Formal participation included semi-structured interviews (Appendix A) and the administration of two instruments: an Ethnic Identity Scale (EIS) (Appendix C) and Self Esteem Scale (SES) (Appendix D). Informal participation in the study included social interaction with other Band members in the daily and ceremonial life of the reserve, consultation in the Band office and observations of family interactions.

Although the CHR, in most instances, acted as the mediator, gaining the women's consent before the investigator made contact, there were a couple of instances where a male member of the family required the woman to withdraw her participation during an interview. The consent of the male had not been solicited by either the CHR or investigator, both assuming the woman would have either discussed it with her husband or been aware of his possible reaction. In both cases, the formal interview was terminated, but informal discussion continued with both the women and the men about more general topics related to reserve life. The hesitancy for participation from the male perspective was related to loss of culture. The male role taken was that of "culture protector".

Confirming the Study

The third stage of the childbering study was undertaken to estimate the degree of reliability and validity of the reserve contacts and to determine similarities and differences of the Coast Salish Band with others of the Coast Salish tribe and with other Northwest Coast Tribes. Both formal and informal contacts were made with Band members and CHR's of the four Coast Salish bands of the

Saanich Peninsula of Vancouver Island. Questions similar to those of the interview guidelines and instruments were used to gather data. Participation in canoe race activities, health fairs and workshops contributed to the data for other Coast Salish bands.

Preliminary comparison of Coast Salish findings with those of other Northwest Coast tribes was made possible through a six-week volunteer experience the investigator was privileged to have in a residential alcohol treatment centre for Native families of the Northwest Coast. Women from the six families participated in interviews, as well as responding to the questions on the EIS and SES. The experience also provided the opportunity to learn how Native families with alcohol problems describe their drinking behaviors and practices and perceive its effects on their lives.

Once these comparisons were made, further discussions took place with two of the women and CHR of the Songhees Band. General findings and interpretations were identified by the investigator and confirmation or suggestions given by the women.

Methodology of Data Collection

This ethnographic research employed several methods of data collection: intensive interviews, event analysis, participant observation and unobtrusive measures.

Interviews

Interviews were solicited from adult female members of the

Songhees Band and when possible their family members. Key informants in the Songhees Band and other Coast Salish Bands of the Saanich Peninsula were also interviewed. Initially the interviews followed suggested guidelines and questions established in consultation with Native peoples in Stage 1. As data were collected and analyzed the interview guidelines and questions changed accordingly so that new, but revelant avenues could be pursued and existing data enriched for greater depth of understanding. Ethnographers believe that interview schedules should be based on a knowledge of cultural patterns and Native language so that information obtained during the interviews is relevant and based on shared understanding between investigator and respondent (Pelto & Pelto, 1978). The questions were phrased in both personal and cultural terms: i.e., to elicit individual's point of view and patterns of behavior in a particular and cultural sense (Spradely, 1979).

The process of data collection for the purpose of this hypotheses generating research was theoretical sampling (Glasser & Strauss, 1967). Data were simultaneously collected, coded and analyzed so that decisions could be made about futher data required and its possible sources. Although many of the questions in the interview guidelines were discussed with each woman, the means of doing this and the details of the probe questions changed. The object was to obtain as much data as possible to identify common factors, as well as relevant differences. The EIS and SES were always administered orally using the same questions and presented at the end of the last anticipated inverview. Paper and pencil tests were deemed inappropriate.

Ethnic Identity Scale

The EIS was adapted from one developed for use with a cross-generational sample of Japanese Americans (Okano, 1977). Wording was changed in the 15 item Guttman scale so that the items were oriented to the Native Indian population. A four point scale from strongly agree to strongly disagree was used. The EIS was scored according to the original scoring; but to date it has not been tested on a Native Indian population, so that the reliability of the instrument has not been established. The concept of ethnic identity is rather elusive and so any single scale which purports to measure and reduce the concept to a number runs the risk of over-simplification if not outright error (Okano, 1977). However, the modified scale used in the limited context of a research measure for the Coast Salish peoples seemed to be reasonably reliable and valid. No similar instrument was found that would measure ethnicity. Graves developed a measure of acculturation, the opposite of ethnicity. The measurement appeared to have "a good deal of internal consistency and covergent validity, while tapping a wide range of acculturation processes" (Graves, 1967:309). Many of the the items were similar to, but scored in the opposite direction of, the EIS. Native consultants and respondents concurred that the items of the EIS were significant aspects of their feelings of "Indianness". Furthermore, content analysis of field notes supported the validity of the items as measures of ethnic identity. Reliability was assessed by comparing responses on the scale items to spontaneous data obtained in interviews. There was a high degree of agreement. As well, when the EIS items were presented to respondents, it was the norm rather than the exception for the respondent

to go into great detail with both personal explanations and examples.

Self Esteem Scale

The Rosenberg Self Esteem Scale (SES) is a ten item Guttman Scale with items answered on a four point scale from strongly agree to strongly disagree. Two items were added at the suggestion of the Native consultants in Stage 1 of the study as being important to the Native people's self-esteem. No reliability or validity measures were available with a Native population. Rosenberg (1965) reports a test-retest reliability of .85 amongst a New York adolescent sample. Similar to the EIS, content analysis of field notes, especially related to concepts of strength and power, supported the validity and reliability of answers to the items of the SES. There was, however, less concurrence by the Native consultants that the items expressed factors important to Native self-esteem.

Participant Observation

In conjunction with interviewing and administration of the EIS and SES, participant observation was a major data collection technique. Observation activities concentrated on behaviors as well as on the settings and circumstances in which the behaviors were seen. For some women this meant observing them in their home and office, the investigator's office, shopping plazas and at Native games and workshops; for others observations were made during several face-to-face and telephone conversations. Participation involved attendance at cultural functions, interaction with the persons observed, observations of

activities and direct participation on committees and in workshops. The focus of the observations and participation was primarily on childbearing issues, their meanings and relationship to social, political and economic context of the culture; and secondarily on broader health and illness issues and everyday Native concerns.

Unobtrusive Measures

Census data, maps, printed and audio-visual material and public health statistics were used extensively. The British Columbia Provincial Archives, British Columbia Museum of Anthropology and National Reports of Commissions were primary sources for this data collection technqiues.

Recording of Data

Extensive field notes were made immediately following each interview or participant observation experience. Since electronic recordings were not acceptable to the women or key informants, they were only used with permission at cultural events. Audio-tapes were used to record Native drumming and singing; while the camera provided the visual record of canoe races, potlaches, dancing and community suppers. Because the ethnographer must raise questions and explore the relationships to other types of data, field notes were reviewed and analyzed on a frequent basis and "memos" were made in an attempt to self-consciously raise the level of analysis and investigation. The memos dealt with methodological and theoretical issues. They consisted of reflections on past experiences and suggestions for futher directions. The methodological memos reflected the operational plan for accomplishing the study and were used

to direct the search for further understanding of nursing and Native perspectives. The theoretical memos represented self-conscious controlled attempts to derive meaning from the field notes. Reference was made to other field note entries for comparisons to literature and resource person references.

One goal of data collection and recording was to remain open to adapting procedures to situations as they unfolded in the field, as well as to create or adapt new procedures and instruments for data collection. Another goal was to develop a triangulated perspective.

Triangulation

Denzin enlarged upon the conventional definition of triangulation as the use of multiple methods in the study of the same object (Denzin, 1978). Triangulation involves varieties of data, investigators and theories, as well as methodologies. This study employed data, theory and methodological triangualtion.

Data Triangulation

Data triangulation included the search for as many different data sources as possible which related to the events under analysis. Where possible mothers and daughters, husband and wives, grandmothers and sisters were involved as sources of date of the childbearing beliefs, values and behaviors as taught and practiced within that family. This allowed discovery of similar and different perceptions of the same event, but posed a problem of some considerable significance to the interpersonal relation-

ships of the investigator to the woman. It was anticipated that if the woman felt, in any way, that her views or information were not considered reliable and that the investigator was "checking up", the respect and trust in that relationship would be threatened and subsequent involvement and reliability decreased. Thus, much effort was spent on discussing the merits of learning from everyone and when appropriate this happened as a family event. Observing the study participants in different locations and at different times of the day and season were used to implement data triangulation.

Theoretical Triangulation

An approach to theoretical triangulation was made by conceptualizing and analyzing the data from a synthesis of Native and nursing perspectives.

> The necessity of considering theoretical triangulation as an integral feature of the research process is shown in those areas characterized by a high degree of theoretical incoherence... (Denzin, 1978:298).

The biosciocultural bases of childbearing is an example where no solidly grounded theory has emerged and thus, empirical data that exist goes unorganized. The few theorists who are working in this area search for data appropriate to her or his hypotheses. Theoretical triangulation permits a tentative resolution of differences for researchers and directs selection of common units of observation, formulation or operational measures of each concept and collection of empirical data. The study has made a beginning attempt at theoretical triangulation in understanding childbearing in its biosociocultural context.

Methodological Triangulation

Methodological triangulation is the employment of multiple methods. These have been described previously under "Methodology of Data Collection". The rationale for this strategy was to maximize the validity of the field efforts (Denzin, 1978).

Sampling

It was necessary to purposively sample in this study in order to cover the fullest range of childbearing beliefs, values and teachings. The target population consisted of post-puberty women and their families. Families of young women in the childbearing age and older women past the childbearing age were considered to be essential to the sample. Within the childbearing age, it was deemed desirable to have women at different stages of experience: i.e. pregnant, postpartum and intrapartum; whereas with the older women it was desirable to have some older mothers, younger grandmothers and elders. The CHR, who knew every member of the Band living on the reserve, selected names according to each of these criteria and subsequently contacted them regarding participation in the study. There were no criteria related to marital status or family living arrangements. Investigator interaction with the other Band members and participation in activities occurred as the situations presented themselves.

Over a twelve month period, the investigator worked extensively on the Songhees reserve with the women and their families, other Band members and Band activities. As many people as possible were included in the study, with

particular attention paid to the Chief and Council members, Band employed CHR, social workers and office managers and elders, as these were people with the greatest knowledge, involvement and history with the Band. Both male and female informants were included for the general aspect of the ethnographic study, but only women were interviewed in depth regarding the specific childbearing beliefs, values and practices as they related to the teachings of the women. The decision to stop sampling after six childbearing and four non-childbearing women were interviewed in depth was based on the fact that no new data were forthcoming with respect to the issues of childbearing.

Reliability and Validity

Although the ethnographic method creates many difficulties in establishing reliability and validity (Robertson & Boyle, 1984), the data collection methodolgy of this study addressed the issue to some extent. The variety of sources indicated a high level of reliability, as did multiple interactions with the same source. Observing interactions among Natives and listening to their support of each other's information: e.g. "Like ____ said, it is true; he speaks it from the heart", "my mother told it, like she said - that's how it is", in public and private settings helped establish reliability. Comparisions with the few other studies available (Horn, 1975; Bushnell, 1981; Jordon, 1983; Smith, 1971) confirmed similar analyses and categories even though tribes and age of women differed. Discrepancies could be explained because of different explanatory models and conceptual frameworks used. When discrepancies occurred among the Coast Salish population, they were clarified with the source in question or with

other sources until the investigator was satisfied that she understood the Native perspective.

Validity was easier to establish over the year of data collection and extensive involvement with the Native peoples subsequently. Construct validity was judged by the degree to which differences between individuals were due to age, sex, experience, education and status. Male responses were used to confirm the females'; young were compared with old; council members and other Band members were observed for similarities and differences.

Content validity was promoted by using women for the women-specific issues and all Band Members and activities for the general cultural issues. The first and third stages of the study were designed to increase content validity.

The use of interviews with observations was the primary means of addressing the issue of concurrent validity. Audio and visual recordings, although limited in scope, contributed as well.

Discrepancies between observations and interviews, when indentified by the investigator were given a logical explanation from the Native perspective. Individual reports of actual behavior were validated often through discussions with other family members or through group interactions, without the necessity of the investigator raising the issue. The predictive validity was surprisingly high, even when the behavior involved such sensitive topics as drinking behavior. Polich (1982) concluded after his review of the findings of empirical

studies and evaluation of alcoholics' self-reports, that the results substantiated the validity of most self-reports. It appears that when behavior that is highly visible is the issue individual reports are accurate, and family members and significant others provide useful validating data on its occurrence. What is more problematic is the reporting of consumption. Similar to Polich (182), the findings in this study suggested that the predictive validity was better for the past six month reported consumption patterns than it was for the more recent past behavior.

The predictive validity of behaviors related to the Native belief and value system were less well established. When individuals reported to the investigator the situation was stated in more realistic terms, whereas if a group of Native peoples was interacting there was a tendency to describe events of the past in more idealistic terms, leaving the distinction between past and present situations up to the listener to distinguish. The importance of keeping Native history alive, which is evident in the integration of historical tales with present-day descriptions of beliefs, values and practices, complicates the determination of the predictive validity.

Data Analysis

In traditional society, everyday thinking as a way of understanding contemporary, western childbearing beliefs and practices is usually complemented by what has been called, by Young (1970), an "uncritical" attitude to the assumptions of the dominant conceptual system.

However, abscence of an overt rival system does not necessarily mean the absence of alternate systems. Two systems may co-exist, with neither competition nor contradiction being evident. Rather complementary ways of dealing with other systems are developed (Young, 1976). These assumptions formed the philosophical foundation for data analysis. The fundamental objective was to change the perception and evaluation of data that was both familiar and unique. Kuhn (1970) defines this as being tantamount to the emergence of scientific discoveries and development of paradigms that provide model problems and solutions to a community of practitioners, e.g. nurses.

This study challenged the Western or "scientific" paradigm as a universally useful means for analyzing what Native peoples are doing about health and childbearing within their normal daily living. It challenged the Western medical paradigm which focuses on the efficacy of medical beliefs and practices and encourages analysts to deal with their subjects in a fragmentary way; it supported the nursing paradigm which recognizes the value of holistic perspective, as well as beliefs and practices encouraging health promotion and self-responsibility; and it challenged health care professionals' beliefs that other beliefs and practices do not, or should not, persist.

Definitions

The analytic approach taken in the study was consistent with the assumption that other beliefs, values and practices are salient to the life events of Native peoples, reflected in both traditional and contemporary behaviors.

The following definitions were operationalized for the analysis.

* **Traditional** refers to that which is communicated from ancestors to descendents, usually by oral communication.

* **Contemporary** refers to that which exists at the present time and is explained in terms of this era.

* **Beliefs** are propositions that people accept as true, that provide them with a rational framework for emotionally important customs.

* **Values** are not simply the choices people make, but their basis for judging the propriety of their choice by the qualities, customs, standards and principles regarded as desirable by the people.

* **Practices** are habitual or customary performances or processes of doing something.

* **Childbearing period** is a stage in the life cycle that extends from conception through pregnancy to six weeks post partum.

* **Childbearing women** are those women who have the biological capacity to bear children.

* **Non-childbearing women** are those who no longer have the biological capacity to bear children, usually because of age.

* **Teachings** are lessons, instructions or disciplines taught formally or informally to provide guidance for individual behavior consistent with Native beliefs, values and social norms.

* **Family** is the kinship network of nuclear and extended family members from an individual's family of orientation and/or procreation. It provides a field for activity and affect in carrying out family functions.

Techniques Used

The data were analyzed using qualitative and quantitative techniques. Descriptive statistics and measures of central tendency were used to describe the results of the Ethnic Identity Scale (EIS) and Self-esteem Scale (SES). All other data were analyzed using a combination of the constant comparative method (Glasser & Strauss, 1967) and developmental research sequence (Spradley, 1979).

Coding and analysis of interviews and observations occurred concurrently with theoretical sampling in order to generate or suggest theory and hypotheses. Two types of domains or categories developed from the analysis: those abstracted from the substantive situations for which there was a Native label for the process or behavior - e.g. teachings, disciplines, Circle of Life, and those constructed by the investigator and abstracted from the language of the research situation - e.g. transactional processes of ethnic identity and education. Theoretical properties of the categories were considered in terms of types (e.g. sources of teaching),continua (e.g. commitment to

teachings), dimensions (e.g. target of outcome of adherence to teaching), conditions under which it was pronounced or minimized (e.g. time of teaching, family involvement), major consequences (e.g. behaviors and reactions to drinking), its relationships to other categories (e.g. ethnic identity) and its other properties.

During the combined process of analyses, Krippendorf's principles of content analysis were employed to improve the replicability of the study (1980).

* Clarity of which data were to be analyzed, how they were defined and from which population they were drawn were addressed.

* The context relative to which data were being analyzed was explicitly recorded.

* Assumptions about how the data and environment interacted were identified.

* The direction of investigation was clearly stated to be childbearing issues.

Process of Analysis

Qualitative research demands a circular, rather than linear, approach to the process, as is evident from the outline which follows. The research cycle started and ended with concept formation, passing through stages of concept development, modification, integration and testing.

* The generation of potential categories came from literature review, other studies and Native peoples' philosophies.

* The potential categories were then discussed with, and modified by, both male and female Coast Salish peoples not living on the Songhees reserve.

* Interview questions derived from the categories were critiqued by the Native consultants as to the holistic, general orientation.

* Subsequent review of field notes and ongoing data collection provided modifications of existing categories and identification of new concepts which were incorporated in ongoing interviews and participant observation experiences.

* All field notes were read and first content analyses of categories made.

* All childbearing interviews were then read, analyzed and major categories finalized for further content analyses.

* Content with context was transferred to category cards after reading through each childbearing woman's file again.

* All cards of one category were read and category definitions developed. Subcategories were noted.

* Data from childbearing women were summarized by major category.

* Further discussions with other researchers and Native peoples indicated that a more explicit Native framework was required.

* Category definitions, subcategory groupings and research domain concepts were reconsidered.

* Non-childbearing data were then read and analyzed according to the revised definitions and subcategories. Each file was read once with analyses done by category, either mutually exclusive or cross-referenced. After second reading, the content and context were transferred to category cards and analyzed with respect to subcategories.

* Subcategories were refined in light of the Medicine Wheel concept. A final list of subcategories was then made and coding scheme developed.

* Case profiles on non-childbearing women were written and qualititive analysis transferred to collective summary sheets.

* Childbearing files were re-read and previous analyses validated or changed in light of the refined category and sub-category definitions. The content was then transferred to category cards with context noted, and subcategories coded.

* Case profiles of childbearing women were written and qualitative analyses transferred to collective summary sheets.

* Case profiles of all women were checked against analyses of the Ethnic Identity Scale and Self-esteem Scale for reliability.

* Other field notes of the Coast Salish were read, analyzed and findings transferred to category cards.

* Summarized analyses of the Coast Salish women were compared to other field note analyses.

* Non-Coast Salish data was reviewed to note consistencies and inconsistencies of categories, as compared to Coast Salish findings.

* Finalization of the concepts and their relationships to each other in the conceptual framework was made.

* Content of chapters pertaining to findings was discussed with several Native peoples, females and males, Coast Salish and non-Coast Salish.

Limitations

The investigator realizes the limitations of this study. In general, it is recognized that no research methodology or data analysis is value free. Even a holistic perspective is fraught with biases. The following limitations are, however, specific to this study. First, the results of the study cannot be generalized beyond the

group studied because of the small and non-representative sample used and the limited access to many aspects of the Native way of life. Generalizations beyond the sample, childbearing event or band must be used with caution.

Secondly, involvement by the investigator in many Native oriented cultural and political events had both limiting and facilitating factors. A limiting factor was the potential influence on objectivity of data, as the investigator got involved in advocacy and caregiving roles. The facilitating factor was promotion and maintenance of a desired relationship involving the development of trust among members of the Songhees Band to increase the validity and reliability of data obtained.

The non-Native status of the investigator was a third limitation, but being female was an asset with the women. Being non-Native posed problems of entry onto the reserve and into family homes and may have biased respondent cooperation and interpretation of the data. Some Native peoples admitted to prejudice against non-Natives, and although the investigator made a conscientious effort to minimize this effect, it no doubt had some influence on the results. However, following completion of the study, the investigator was asked to give a workshop on communication for women on the reserve and to participate in a Vancouver Island Native Woman's Health Conference: both indicators of a certain level of acceptance.

Having the CHR act as a mediator introduced potential bias into the selection of subjects, the interpretation of the study to them and their subsequent responses. However, several of the women, after participating in the study,

made suggestions and contacts for the investigator to follow up on. Thus, a gatekeeper bias was reduced to some degree and the initial interpretation of the study was diversified.

The potential bias introduced by limitations of numbers and nonprobability sampling was addressed, in part, by the process of triangulation, but should still be considered a limitation of the study. It is unknown whether all women informants were representative of the Band members and whether they witheld important information.

A sixth limitation focusses on the complexity of the kin network behavior and perceptions. Simple, unidimensional concepts were not delineated, but rather multiplex variables emerged, providing a gestalt of the phenomena, but limiting the interpretation of any causal relationships.

Individuals often feel uncomfortable about disclosing information about behavior they consider improper, unconventional, private or exceptional. Because such sensitive issues have the capacity to influence behavior and excite feelings, responses to interview questions and investigator may reflect impressions from external influences, relationships with significant theories and susceptibility to ideal, not real. To reduce these limitations, the investigator made a determined effort to : 1) ignore stereotype expectations and recognize cultural diversity, 2) respect marital, family and group solidarity and obligations, 3) describe the research project as something that had potential to the Band members, 4) use familiar wording in open-ended culturally relevant questions, and 5) ask questions about sensitive issues after trust had been established.

Language difficulty was an eighth limitation. In some instances there was no English translation for the Native concept, which inhibited description and understanding. Some of the Songhees people were concerned with their facility with the English language, so all interviews used simple language, with alternative terminology when appropriate.

The last limitation to be considered in this study was the concerns for anonymity and confidentiality. Because of the small population of the Songhees Reserve (a little over 100 people), it is likely that any report which includes individual behavior, even without the use of names, can have its source of information traced to the particular individual(s).

Confidentiality, like anonymity, is viewed as difficult to maintain. Not only do other family and Band mambers want to know what a respondent has said, the investigator's opportunity to validate the respondent's information is severely limited. Without paying particular attention to this, confidentiality is easily mistreated and trusting relationships destroyed. The study therefore does not report any individual data, and examples do not identify source. Extensive examples are composites of several sources.

Field Research Issues

The attention paid to ethical principles in conducting the field work in this study was based on the principle of respect for human autonomy and the recognition that cultural

beliefs and practices may be sensitive topics. This study entailed a good deal of subject-investigator interaction and the investigator was cognizent of the ethical requirements of field work. Because the investigator had comparatively little power over those who were studied or over the research setting, patience, respect and persistence were required. Acceptance of individual rights and respect for their decisions had to take precedence over the frustrations experienced.

When sensitive issues such as spiritual practices or drinking behavior were explored, the investigator was cognizant of feelings of discomfort and reticence and withdrew from asking more probing questions. Direct recording, audio or visual, was perceived by the Native peoples as a means of losing their culture and thus was not used, except for acknowledged public events.

When more information was shared than the respondent felt confortable with subsequently, the investigator assured the individual that it would not be used. This related predominantly to cultural practices. Discussions about cultural beliefs and values were acceptable to the Coast Salish people once they trusted the investigator not to ridicule or criticize them. However, sharing knowledge about the practices (e.g. initiation, Longhouse activities, dances and medicines) was considered a violation of the Native sacred way of life, and when this occurred the woman or informant tended to terminate the interview.

The position of field worker-investigator had to be negotiated over time and the social construction of it had to

be flexible to accommodate changing attitudes of the Band members. Those subjects considered sacred were never referred to again; reference between women or informants was never made; and interview questions were altered to minimize any perceived control or coercive power. The private intimate nature of some behaviors (e.g. drinking, child neglect) of the respondents raised ethical issues of child welfare, legal issues of Native status and confidentiality issues in intervention. Cassell (1980) suggested that by concentration on intent, rather than results, the categorical imperative would make it easier to weigh such decisions, "they are acceptable when people are treated as ends, not means, and their autonomy is respected" (Cassell 1980:36). Except when advice was explicitly asked for, the investigator made no attempt to intervene.

The intent of the study was to place sensitive issues within the broader context of childbearing and health and recognize the virtues, pride, identity and strengths of the Band, family and individual within the context of the Coast Salish culture. The interview had its roots in the categories of common-sense thinking of the Coast Salish culture, so that sense was made out of the enviromnent and meanings and knowledge achieved in a nonthreatening atmosphere. Confrontation and checking out responses for consistency and depth were perceived as inappropriate techniques (Cicourel, 1974).

The issue of entry was discussed earlier in this chapter. It was of utmost importance to the success of the study. This, plus the other issues of field work, were addressed to improve the reliability and validity of research dealing with potentially sensitive topics.

CHAPTER IV

CONTEXT FOR NATIVE WOMEN'S CHILDBEARING PRACTICES: HISTORICAL PERSPECTIVES - CONTEMPORARY LIFE

Introduction

The experience of childbearing is viewed by individuals within the context of their cultural environment. Contemporary and traditional values and beliefs affect every aspect of an individual's social and personal life because roles within the childbearing experience are associated with specific expected behavior. Aamodt (1978) identified four subsystems of a culture that need to be understood in the study of childbearing: moral and value system, kinship system, knowledge and belief system and ceremonial and ritual system. Each of these systems might be considered to include cultural content, historical development and experiences, and a group image specific to the ethnic group. Combined, the culture subsystems and these elements comprise the contemporary situational context for the childbearing experiences of women belonging to a band of the Coast Salish tribe.

The purposes of this Chapter are to give a historical perspective to the concerns of Native peoples in Canada: concerns which include family life and alcohol use. Issues, beliefs and practices common and specific to the Coast Salish peoples of the West Coast will be presented as the context for the Songhees peoples' teachings and practices related to childbearing. This ethnographic study of childbearing took place primarily with the Songhees Band, one of many belonging to the Coast Salish tribe on Vancouver Island.

The methods used for data collection included reviewing materials in the Provincial Archives offices of British Columbia and Native organizations, discussing the past and present with elders and council members of several Coast Salish bands, reading stories penned by Native writers or recorded by non-Native authors, analyzing ethnographies, records and commissioned reports on Native ways and issues and reviewing actual or recorded Native customs. Taken together the summary of data provides the background for the analysis of today's issues. The context for health and childbearing issues is highlighted.

The Coast Salish, a tribe of Northwest Coast Native peoples, although unique in many ways, share many of the traditions, history and experiences of other tribes in the same area, and with other Canadian and American Indians. Understanding their specific cultural orientation and social organization requires an appreciation of the Native situation in general. It is not the intent of this Chapter to give a comprehensive review of the historical and contemporary events that have shaped the present Native situation and childbearing orientation, but rather to highlight those aspects that have, and continue to have, an affect on the health and well-being of the Native peoples, especially during childbearing.

The Native Situation in Canada: Past and Present

Moral and Value Systems

> The view of history held today by most non-Native Canadians and the perspective held by most Native peoples are almost mirror images (Penner, 1983:12).

Native Peoples consider the "discoverers" and "explorers" to have been intruders in a land already well known to the Natives that inhabited it. The Natives know themselves as having been productive, cultured, spiritual, and intelligent civilizations long before the white man. But they have been portrayed by non-Natives as savages and pagans, unknowing of religion and needing instructions in simple tasks. The negative sterotypes of "lazy Native", "drunken Indian" and "wanton squaw" have been one-sided, not reflective of the Native peoples' perception of themselves.

Stereotypes are based, at best, on partial knowledge only: built up around some aspect of behavior, real or imaginary, which is deemed to be characteristic of the group in question, and which becomes the basis for the evaluation of individuals belonging to the group as a whole (Epstein, 1978).

> Because only a one-sided, negative portrayal has been widely disseminated, non-Indian Canadians are poorly prepared to understand the perspective held by Indian people (Penner, 1983:12).

The Native perspective is beautifully illustrated in an Indian Creed: a statement of traditional and contemporary values and beliefs which are reflected in many of their teachings and culturally-relevant practices.

An Indian Creed (reprinted in Kakawis Star, a Native Treatment Centre Newsletter; source unknown)

1. While he believed in many gods, he accepted the idea of one Supreme Spirit, who was everywhere all the time, whose help was needed continually, and might be secured by prayer and sacrifice.

2. He believed in the immortality of the soul, and that its future condition was to be determined by its behavior in this life.

3. He reverenced his body as the sacred temple of his spirit; and believed it his duty in all ways to perfect his body that his earthly record might be better.

4. He believed in the subjection of the body by fasting, whenever it seemed necessary for the absolute domination of the spirit: as when, in some great crisis, that spirit felt the need for better insight.

5. He believed in reverence for his parents, and in old age supported them, even as he expected his children to support him.

6. He believed in the sacredness of property. Theft among Indians was unknown.

7. He believed that the murderer must expiate his crime with his life; that the nearest kin was the proper avenger, but that for accidental manslaughter compensation might be made in goods.

8. He believed in cleanliness of body.

9. He believed in purity of morals.

10. He believed in speaking the truth and nothing but the truth. His promise was absolutely binding. He hated and despised a liar, and held all falsehood to be an abomination.

11. He believed in beautifying all things in his life. He had a song for every occasion, a beautiful prayer for every stress. His garments were made beautiful with painted patterns, feathers, and quill-work. He had a dance for every fireside. He has led the world in the making of beautiful baskets, blankets, and canoes; while the decorations he put on lodges, weapons, clothes, dishes, and the dwellings, beds, cradles, or graveboards, were among the countless evidences of

his pleasure in the beautiful, as he understood it.

12. He believed in the simple life. He held, first, that land belonged to the tribe, not to the individual; next, that the accumulation of property was the beginning of greed that grew into a monstrous crime.

13. He believed in peace and the sacred obligations of hospitality.

14. He believed that the noblest of virtues was courage, a virtue he worshipped and prayed for above all other qualities. So, also, he believed that the most shameful of crimes was being afraid.

15. He believed that he should so live his life that the fear of death could never enter into his heart; that when the last call came he should put on the paint and honors of a hero going home, then sing his death song and meet the end in triumph.

Not only did the white man have problems in understanding the Indian's culture, there existed different interpretations about the definition of "Indian". The definition problem arose after extended contact, intermarriage and the subsequent loss of "pure Indian blood" in the following generations and from the legislated policy of assimilation, whereby some of the Indian identity was supposed to have been lost (Duff, 1964). To the Native peoples, the definition of "Indian" was unimportant. They were proud of their Indian identity and readily acknowledged their ethnic background.

To the non-Natives, knowing who was defined as Indian was critical to their objectives of accessing all land and resources and reducing the Indian influence and claims. This was to be accomplished by culture change (preferrably

integration and assimilation) or enfranchisement. Two significant pieces of legislation and their subsequent amendments were passed in the 1880's to support these objectives.

Section VI, 91 (24) of the British North America Act (BNA Act) 1867, now the Constitution Act, 1982, assured that Native peoples would be legally different from other Canadians and be restricted in their opportunity for self-government. Parliament was given the legislative authority over "Indians and Lands reserved for the Indians". Until the early 1980's the Constitution was held in England and changes had to be made by the Monarch. Now that the Canadian government has brought the Act home, changes can be made through procedures laid down in the 1983 Constitutional Accord and in the Constitution Act 1982 (Munro, 1984).

The 1867 Indian Act legislation was intended as a measure to reduce the number of Indians and halfbreeds on reserves as part of government's stated policy of doing away with reserves and of assimilating all Native people into the Euro-Canadian culture (Jamieson, 1978). The intent was to reduce the cultural differentness of the Native peoples, but in fact it served to emphasize it.

> The Indian Act is a comprehensive piece of legislation that circumscribes activities in all sectors of Indian communities. It places constraints on the rights of Indian people and bands and limits their ability to govern themselves effectively. (Penner, 1983: 17)

There was, and is, no recourse through the Bill of Rights to these legislative discriminations, since the Indian Act

has special status as protective legislation under the Constitution and can only be altered by Parliament, not by a court (Jamieson, 1978).

By subjecting the Native peoples to special legislation the Federal Government established a retrenched paternalistic attitude toward them. Their public affairs were, and continue to be, administered by Indian Affairs, a special branch of the Federal Government, while health services are determined by Medical Services Branch of Health and Welfare Canada. Although, they possess lands of a special legal category - Indian reserves - they do not have full control of the reserves or the members.

Ceremonies and Rituals

In 1880 a new and separate department for Indian Affairs under the Minister of the Interior was created because, Prime Minister MacDonald said, "The duties of the Indian Branch are so onerous." (quoted in Jamieson, 1978:45). These onerous duties focussed on supervising policy implementation, the aim of which was assimilation. This was to be accomplished by Indian Affairs accustoming Indians to European lifestyles, customs, beliefs and values, and attaining more economical control over their affairs supposedly during their transition to civilization and Christianity.

One facet of the civilizing and Christianizing process was an 1884 addition to the Indian Act forbidding Indians from holding traditional Indian festivals, such as the Potlatch. These festivals symbolized and affirmed group unity and were integral to the cultural and spiritual beliefs of the

Indians on the West Coast (Amoss, 1972). The Potlatch was a traditional Indian governmental system. From time to time, community or national leaders called assemblies which were widely attended. Through ceremony, song, dance and speeches, new leaders were installed in office; wealth was redistributed through an economy based on giving rather than accumulating (Penner, 1983); names were given, recorded and witnessed by the guests; and political councils were held and decisions made as history was recalled and instructed. Common to all these activities was the giving of spiritual guidance. Although different from the European customs of governmental organization, it contained all the necessary elements to maintain continuity, good government, a sense of identity, ability to conduct group affairs and determine the course of their destiny (Penner, 1983). However, under the new law, anyone who took part in such customs as the Potlatch was subject to six months in jail (Jamieson, 1978).

Sir John A. MacDonald's perception of the Potlatch differed considerably from the Native peoples'. This Prime Minister stated

> ... the 'Potlatch' is a misdeameanor. This Indian festival is debauchery of the worst kind, and the departmental officers and all clergymen unite in affirming that it is absolutely necessary to put this practice down (Potlatch Law, 1884).

The prohibitions remained in effect until 1951 when references to Potlatches and winter ceremonials were left out of the Indian Act (Duff, 1964).

As with the Potlatch law, the 1860's restrictions were also put on Indians regarding the sale and consumption of alcohol. It was illegal to sell liquor to Indians and to live within 50 yards of the Indian reserve or camp (Aamos and Boyd, 1980). When the prohibition of the Potlatch was removed the Indian Act was revised to allow Idians to drink in public places, but it was not until 1962 that sales restrictions were removed so that liquor could be legally sold to Native peoples for private consumption. Although possession of liquor on reserves is now subject to Band plebiscite, it is almost impossible to enforce (Duff, 1964), and very few reserves attempt to do so.

For purposes of implementing the 1880's legislation it was necessary to define who was "Indian". This was simple for the Native peoples. The ethnic group calling themselves the Native peoples considered themselves such, regardless of "blood" content. The distinction of half-breed, metis etc. came about through political and governmental requirements. For federal legislation and policy "Indian" had to be defined and distinctions made. The Constitution, 1982, refers to Indians, Inuit and Metis in an aggregate manner as the aboriginal peoples of Canada, but in the 1880's the federal government divided Native peoples legally into three groups, each with specific rights and obligations. The three groups were status Indians, non-status Indians and Eskimos.

Status Indians are people legally entitled to the benefits of programs under the Indian Act and the various treaties. The names of the original holders of this status were recorded with the federal government in 1869 and the lists were kept up to date by the bands according to patrilineal

succession (Burnaby, 1980). In some Canadian provinces, ancestors signed a treaty with the representatives of the queen and ceded some land rights to the crown in return for specific rights. Where treaties were made, those who signed, plus their descendants, become legally known as status Indians. Since no treaties were signed by the federal government and Native peoples in the province of British Columbia, ancestors of todays' status Indians had to chose to be regarded as such and become registered under the Indian Act, 1876 (Cardinal, 1969).

All status or registered Indians belong to a band, the unit still recognized as an administrative group by the federal government. Most bands are entitled to inhabit a reserve, a tract of land held for their use by the government. Reserve land cannot be sold and is not subject to Provincial legislation or zoning regulations (Duff, 1964). Status Indians who live on reserves are exempt from almost all taxes (land and personal property and income earned on the reserve), have the right to health care and education provided by the federal government and get special construction on the distribution of government funds for social and economic purposes. Status Indians who do not live on their reserve lose some rights to benefits, such as health care, but do not necessarily lose their Indian status. Under this tribal-type policy the individual who decides to leave the reservation must face the fact that the government's policy is to support the tribal/band unit instead of the individual. However it is worth noting that this rejection policy is in direct conflict to long standing Canadian government philosophy of assimilation.

Non-status Indians are people who claim to be of Native ancestry but who do not have Indian status. Many have lost their status through the marriage regulations of the Indian Act, and others through enfranchisement. In some cases, they did not get status because their ancestors were not recorded on the federal lists. These Native peoples are referred to as Metis.

Since 1869 Indian women in Canada have been subject to a law which discriminates them on the grounds of race, sex and marital status. The 1970 Indian Act declares that a status Indian woman who marries a non-Indian man forfeits her status and that of her children. She ceases to be an Indian within the meaning of any statue or law in Canada (Indian Act, 1970). However, states Jamieson (1978:1)

> The consequences for the Indian woman of the application of section 12(1) (b) of the Indian Act extend beyond that.

The woman on marriage must leave her parents' home and her reserve, she may not own property on the reserve and must dispose of property she does hold. She may be prevented from inheriting property left to her by her parents and from returning to live with her family on the reserve, even if she is in dire need, very ill, a widow, divorced or separated. Her children are not recognized as Indian and are therefore to a great extent denied access to cultural and social amenities of the Indian community. Thus, the oppressive legislation affects the Indian woman and her children materially, culturally and psychologically (Jamieson, 1978). On the other hand, a non-status woman of any racial background becomes a status Indian if she marries a status Indian, and can then enjoy all the

resources available to status Indians.

An Indian can also lose status by becoming enfranchised, either by choosing to do so or ipso facto by gaining a university or professional degree, such as in law, medicine, or religion (Jamieson, 1978). The original purpose of enfranchisement was to provide full legal rights as citizens. According to Cardinal (1969), if you wanted the right to vote, to drink liquor or become a full citizen, you had to give up Indianness. You could not be both Indian and Canadian.

Until June 1985, enfranchisement was not reversible. Loss of treaty or aboriginal rights such as membership on reserves, title to part of the resources or reserve land and opportunity to return to the reserve where family and friends lived was passed on to children and direct heirs (Cardinal, 1969). Although provincial voting rights were given to the Native peoples of British Columbia in 1949, it was not until 1960 that they were enfranchised for federal elections. There is now little to gain from choosing enfranchisement, other than obtaining one's share of the Band's holdings, and today this share is relatively small in comparison to the value of the entitlements of Indians status. Until June 1985, marriage was really the only route for enfranchisement: a route that is prescribed, not chosen. The Indian Act has been revised to reverse enfranchisement, so that Native women and their childbearing can apply to be reinstated at Status Indians.

> If you are legally an Indian, then you and your family can live on reserves and are entitled to certain limited rights. No matter how fullblooded you may be, if you are not legal Indian, you can forget the reserve, you can't live there. (Cardinal, 1969, 18-19)

Non-status Indians are not entitled to the benefits of the Indian Act, which in many areas is of crucial economic importance. Apart from financial losses, educational losses may be significant. In recent years there have been bilingual and bicultural programs available on reserves to open the door to a heritage of Indian culture. These programs, plus school supplies and supplements, daycare facilities and nursery schools, and post-secondary educational allowances are all denied to non-status Indians. Psychological effects of discrimination reflect identity changes, cultural differentness, rejection by white and sometimes Native society and alienation from family, relatives and life of their former communities (Jamieson, 1978).

The distinction between status and non-status Indians is by no means clear and has created many sociocultural and economic problems for the Native peoples and difficulties for those planning and administering health and social services. For instance, the proclamation to the 1888 amendment to the Indian Act created a modified definition of Indian for the purpose of enforcing the section prohibiting the sale of liquor to Native peoples. The expression "Indian" was extended to, and included, any person, male or female, who was reputed to belong to a particular band, or followed the Indian mode of life or any child of such a person (Jamieson, 1978). Thus, when it suited the government, a non-status woman and her children became Indians temporarily.

Even when the distinction between status and non-status is relatively clear, disputes can arise between two federal government branches serving the same group: e.g. Indian and

Northern Affairs, and Health and Welfare Medical Services Branch. To add further complications to the situation, the definition of "Indian" or "Native" used for the federal government statistics differ from the definition used in the Indian Act. The definition of "Indian" was different from either of these when it came to deciding who could and could not buy liquor from a legal perspective.

The definition of Registered (status) Indian is the legal definition used by Indian Affairs Department of the federal government and applies to people who came under the jurisdiction of the Indian Act: whose names are included on the official registrar. Individuals acquire legal Indian status at birth or, for non-Native woman, by marriage to an Indian male. A name can be removed from the registrar by enfranchisement to become a legal Canadian citizen, but this seldom occurs now. For a woman, past conditions required that her name and the names of her children were removed when she married a non-Native.

A broader definition of "Indian" is used by the Dominion Bureau of Statistics and Division of Vital Statistics. They define Indians as all those Canadian residents whose racial origin, traced through the male, are Indian. Thus, one is defined as "Indian" at birth and only ceases to be an Indian at the time of death. Thus status, non-status and Metes Indians could be included in the statistics.

The differences in operational definitions of Native Indian and thus incongruencies of how and what statistics are compiled makes it almost impossible to obtain an accurate picture of the Native peoples' historical and contemporary health and social status. Interpretation is ambiguous at

best, as the definitions do not necessarily apply to the same group. It is difficult to determine which Indians are included in the statistics; registered status Indians, or non-status; or those who claim to be such because of racial origin and preference. Most authorities agree, however, that whatever is reported is the minimum and probably under-represents the Native peoples' position in Canadian society. (1985).

Kinship

Regardless of the aforementioned definitional problems tied up with treaty and aboriginal rights, the legal definitions fail to solve the real human problems of identity. Cardinal poignantly states "To an Indian, being Indian in Canada simultaneously and automatically means being Canadian. ...Indians' homeland is called Canada" (Cardinal, 1969:25). Other Native peoples would argue that homeland is more specific; it is the land of the tribe (Wilson, 1985). It is the land where localized groups of Native people lived together throughout the year. These groups were bound by ties of kinship which emphasized the saliency of contiguity as they moved to seasonal resources owned by kinfolk. Clusters of villages became so closely identified with one another by virtue of locality, dialect, culture, and intermarriage that as units they became indistinct and bore a common tribal name (Duff, 1964). Although the Native peoples formed bands for cultural reasons, the federal government's Indian Affairs fixed a legal meaning to it for purposes of Indian administration. Alleviation of administrative jurisdictional problems at the federal, regional, and band/tribal levels was not

realized however, as they can still be found today, reflected in gaps in health care.

Today's administration of the Indian Act remains very similar to that of the 19th century, even though Indian Affairs is now incorporated into the Federal Department of Indian Affairs and Northern Development. In British Columbia, Indian Affairs has nine districts, each with an Indian agency. The agency's responsibility for bands and reserves in the district includes allocation of federal band funds. Each band is required by the Indian Act to be governed by a council comprised of a chief and ten to twelve councillors. Band council members serve a two year term, gaining office through election or traditional custom (Duff, 1964). No restrictions exist for the number of re-elections. Some bands have had the same leader(s) for 20 years, others have experienced more internal strife and council members have changed frequently.

From the perspective of non-Natives, the main purposes of the current Indian Act are to provide Band Councils with the management and protection of Indian lands and monies, to define certain Indian rights, such as exemption from taxation in certain circumstances, and to define entitlement to Band membership and to Indian status. Under present legislation, Band Governments have similar powers to those of local Governments under provincial systems (such as zoning, control of domestic animals, provision of local health programs, maintenance of local law and order and definition of minor offences). They also have special rights in relation to the "preservation, protection and management" of fish and game and punishment of trespassers. Bands recognized as advanced have additional local

Government powers in relation to taxation, appropriation and the appointment of officials.

However, subject to the present Indian Act, neither the band, nor the band council, can be incorporated for the purposes of establishing a band self-government. At no time does either have exclusive jurisdiction over Band affairs (Hunter and Associates, 1978). The band is responsible for the management of public works, traffic, housing, and sanitation, and to some extent health and social services, but in no way is this analagous with self-government. The band council is administering Departmental policy of Indian Affairs and Northern Development and Health and Welfare Canada in which they had no decision-making nor consensual input. Departmental control of Indian activities has been a consistent element of Indian life. In the past, an Indian agent representing the Department at the local level had control over virtually all aspects of life. Although the Indian agent has disappeared, the Department still exercises considerable control over band governments. Penner found in the Task Force hearings on Indian Self-government that "...witness after witness said that the Department makes planning and budgetary decisions without adequate input from the bands. Chiefs and councillors felt constrained by a system that does not enable them to respond to the needs of their communities" (Penner, 1983:17).

From the Native peoples' perspective there are five practical difficulties with the Band's present status. First, the exercise of all these powers is subject to various kinds of control by the Minister and/or the Governor in Council. In most instances, the Federal

Government's power of discretionary control of bylaws and other powers is not exercised in practice if a band is acting within the law. The fact that it exists, however, complicates the accountability of Band Government and often leads to interminable technical complications to accomplish the simplest act.

Second, it is not possible to grant Bands full managerial power over reserve lands under the present Indian Act. The Minister can only delegate his authority to individuals within the Band to act as his agent. In such cases the Crown still retains the ultimate responsibility and accountability and therefore limitations must be placed on the exercise of the delegation.

Third, the Minister also has trust responsibilities in relation to Band monies which prevent him from permitting Band Governments to control their own assets. Band councils and their members cannot use them as they would wish for their own development.

Fourth, the Band Governments have few legislative powers in social and economic development areas. The Department of Indian Affairs has delegated the administration of many such programs to numerous bands, but has retained the power of program definition. Many Native peoples consider present social and health programs to be inappropriate to their specific needs, priorities, and customs.

Fifth, the legal status of Band Governments has been put in question by the courts. It is currently unclear whether Band Governments have legal power to contract with other legal entities (Minister of Indian and Northern Affairs).

It is increasingly evident that certain local groups, bands and/or tribal councils, have a life of their own and not just that which is merely delegated to them by other jurisdictions. They are capable of directing their own concerns. Their interest in themselves is usually sustained and directed by their sense of responsibility. If one acknowledges this perspective, it becomes readily apparent that band council is in a particularly awkward position. It is accountable to the Department of Indian Affairs and Northern Development for moneys received, but it is also accountable to its people, whose priorities and needs are often at variance with Departmental requirements. While various policy directives have emphasized consultation with bands, real control still rests with the Department.

Indian Band members are also subject to a number of jurisdictions that only have in common their differences: the by-laws promulgated by their Band councils, federal laws, and provincial laws of general application except where they conflict with treaty rights. Since, under the present Band council system, the powers, capacities and responsibilities of Band Councils are limited and poorly defined, Councils often find themselves making decisions with regard to matters over which their jurisdiction is unclear or else very restricted. As a consequence, Band councillors increasingly find themselves coming into jurisdictional conflict with the federal, provincial and municipal governments (Minister of Indian and Northern Affairs). Native control does not form from a weak delegation of authority, but must be recognized as a legitimate and capable entity (Cardinal, 1969).

Today there are a variety of opinions as to what the exact nature of band local government representatives agree that there must be. Both Native peoples and federal government representatives agree that there must be a definitional understanding that incorporates both legal and political issues. At least two questions must be answered. Who has powers for the benefit of the members within a geopolitical area (i.e. reserve) to govern specifically a defined population (i.e. Band members)? Who has the authority to act for the general public and to function as an agent of the province? (Hunter and Associates, 1978).

Recognizing the need to address the issue of Indian Self-Government, the House of Commons ordered that a Special Committee be appointed to act as a Parliamentary Task Force on Indian Self-Government (Penner, 1983). All legal and related institutional factors affecting the status, development and responsibilities of band governments on Indian reserves were reviewed.

Among the conclusions in the Penner Report of this task force (1983) were recommendations that (1) the right of Indian peoples to self-government be explicitly stated and entrenched in the constitution of Canada; (2) the Native peoples could be self-governing in areas in which they wish to legislate; and (3) each band should decide its membership, without regard to the restrictions of the Indian Act. The Government of Canada's response to these recommendations, and others in the report, was on the whole favorable, but cautious. Health Minister Munro stated "The Government looks forward to working in concert with the Indian First Nations and in consultation with the Provincial Governments to achieve the aspirations of the

Indian people for political, economic, social and cultural development" (Munro, 1984:7). As of April 2nd and 3rd, 1985, formal talks between the Indian First Nations and Government of Canada had begun, but to date (September, 1985) no changes have been made. The Native peoples' concerns have not altered.

During the Task Force hearings, Indian witnesses gave convincing testimony about the importance of Indian control in areas central to the cultures of the Native peoples. They asserted that in some cases only Indian control of legislation and policy would ensure the survival and development of Indian communities. Indian control was deemed necessary in three areas: education, child welfare and health (Penner, 1983).

Family Life

Defining the Family

Janice Kekahban, speaking at the 1978 American Indian/ Alaskan Native Nurses Association stated that

> ....(we) define ourselves not so much as individuals but as members of the family and tribal groupings. The family for Indian Natives includes the nuclear family, extended family and certain other individuals bound by ties of friendship or community. It is not unusual, for example, for Indian families to raise offspring who, for some reason, have no blood related family. It is not unusual for certain women to be defined as "aunt" and to hold certain roles of respect and responsibility for all members of the community (Kekahbah and Wood, 1980:vii).

This definition of family is holistic and is in keeping

with traditional Native concepts of health and of life in general.

Red Horse (1980) states that tribes generally define family according to three dimensions: (1) household (2) extended family through second cousins and (3) clan/band membership. He identifies the supportive functions as, "Family in this context represents the cornerstone for social and emotional well-being of individuals and communities" (Red Horse, 1980:1). On the other hand, Speck and Attneave acknowledge the fact that at times the extended family network may be a source of stress for its members, "our experience is that in some instances the entire social network causes and perpetuates pathology, scapegoating the individual and/or family" (Speck and Attneave, 1973:xxii). Thus, the family may be conceptualized as having the potential of providing an environment with degrees of supportiveness and/or stressfulness.

Native extended family kinship roles are defined along lines that are different from that of white middle-class. Native families normally include adoptive relationships, whether legally or formally recognized, or merely sanctioned by custom and tradition (Speck and Attneave, 1973). Native family networks are structurally open and assume a village-type characteristic, inclusive of several households representing significant relatives along both vertical and horizontal lines (Lewis, 1980). Within the Native family cousins may have roles similar to those ascribed to siblings in the white middle-class nuclear family. The aunt and uncle roles within the extended family may be more similar to parent roles within the white middle-class nuclear family. In these extended families,

from the beginning, the child experiences more multi-parenting than single parenting (Kekahbah and Wood, 1980). "It wasn't only the parents that raised the children, but it was a total family process" (Ryan, 1980:28). To maintain strength in the family members had to be extended beyond the immediate parents.

Speck and Attneave (1973), Red Horse (1980), and Guillemin (1975) refer to the concept of social or tribal family network to describe the nuclear family and all of the kin of every member, as a multigenerational extended family. Friends, neighbors and significant others who risk involving themselves with the family's or individual's problems or health concerns are also included in this definition. Attachment to kin and participation in close friendship circles defines and maintains the boundaries of the group with which one identifies. However, the force which attaches one to a particular group is not transmitted in the genes, it has to be created anew in each succeeding generation (Epstein, 1978).

The network concept permits a definition of family that can put aside the usual concern over structure and composition and instead consider the enduring patterns of culture that spread over time and space. Family networks contribute significantly to the important ritualizations marking birth, death and marriage. The members significantly impinge on each other's lives because the dailiness of relationships within the network have a quality of regularity and of intrusiveness into the past, present and future. Particular cultural behavior based on the Native peoples' structure of beliefs, values and meanings

contribute to the network's process of continuity and stability.

Family Functions

Guillemin (1975) identified three assumptions of the network concept underlying the interactions between the Micmac Native peoples and industrial society. (1) While individual members may at times interact with non-Indian or with Indians from other tribes, all associations are directed by cultural goals so that interaction with fellow tribesmen is more highly valued than relationships with outsiders; (2) family and community, rather than individual, goals dictate the nature of the groups' boundaries. Native peoples prefer each other's company, with little intrusion from outsiders, such as non-Indians wanting to associate with them as equals; and (3) family and tribal network provide multiple bonds between individuals: bonds of kinship, reserve ties and a shared history of human relations. These assumptions, based on traditional Native values, are helpful in understanding the ethnic identity function that Native families carry out in contemporary Canadian society.

Manson (1979) described how the American Indian family takes on different functions depending upon the kinship process utilized by a particular tribal group. Society structures the kinship relationships in very definite ways so that each member has a definite and distinct role in which to function. Different tribal groups describe these roles differently, but sufficiently so that each individual is well aware of her or his responsibility to the family

unit (Ryan, 1980). In speaking about the American Indian family Manson (1979) stated

> (f)irst, members aid and protect one another; their collective liability for the others' actions regulates individual behavior (Manson, 1979:4).

Secondly, the family functions as a basic unit of social and cultural expression. The well defined roles and expectations that give identity to the individual family member are passed down through generations.

This social network, although sometimes invisible, is a very real structure in which the individual, nuclear family, or significant other is embedded. Its high degree of information exchange properties gives it the potential to be malfunctioning or functioning, providing degrees of support or non-support (Speck and Attneave, 1973). In Native communities the family network is the central core of their society, especially with respect to childbearing and childrearing. Mead and Newton (1967) found that the Native families provided four key aspects of assistance to childbearing women. The first was help with fertilization, defining the suitability and qualifications of the partner. The second type of help given was protection from injury. Economic help and personal assistance and care to alleviate the stresses of childbearing were the other kinds of help. The manner in which the help was given and its extent - whether minimal or maximal - depended on the tribe. Childrearing practices teach the child to think of her developing self and life destiny as inseparable from that of the family and tribe. The network of kinships, especially the terms and relationships within the family, provide the chief model for the child's experience of the

world (Romeny and Paul, 1973). This model contrasts with that of Western society, where many of the functions of the family tend to be taken over by schools, welfare agencies and other special-purpose institutions. Western child-bearing practices prepare a child from an early age to transfer her interests and loyalties from the family to other persons and groups and to operate independently and successfully in an individualistic society (Romney and Paul, 1973), where as Native families encourage interdependence and respect for extended, intergenerational family relationships.

Conceptualizing the Native family as a social network is relevant to the understanding of the family as environment for the childbearing woman.

> In the past, the extended family system was a support system and also an educating system (Walker, 1980:41).

The grandparents were the main socializing agents in the child's upbringing. Children, at an early age, were taught to respect their elders. By having this respect and attention of their children from an early age, the elders had opportunities to teach many things. By example and by instruction children learned the behavior befitting a respected adult and the etiquette required to avoid bringing shame to their family or their names into disrepute (Mithun, 1983). For example, traditional role expectations of wife and mother were passed from mother to daughter through daily experience, not in classrooms or from books (Hungry Wolf, 1982; Patterson, 1962). They were also learned through helping the elders, developing friendships, and attending traditional ceremonies.

Myths, various rituals and other activities which translated myths into social reality were told through all ages, contributing to the group's sense of its own continuity (Epstein, 1978). Legends, often allegorical in form, were lessons about environment, behavior and responsibilities.

> The time of story telling wasn't something that was planned for every day, it was a time in which our grandparents knew that it would teach us the most (Walker, 1980:47).

For instance, learning about childbirth did not occur until the woman was pregnant with her first child.

> As the agent of primary socialization, the family is the conduit, the shaper of roles its members play in society, the arbiter of morality, and the maker of values, beliefs and attitudes that determine how individuals behave ... (Mithun, 1983).

The role of grandparents was particularly important for the transmission of cultural values and impressing upon the individual the importance of the good will of society (Patterson, 1962). Good will could be won and maintained by repecting the traditional obligations of kinship and by avoiding involvement in quarrels. Confrontation was not an acceptable way of identifying differences or discrepancies.

The family network also plays a predominant role in the development of ethnic identity and adaptive potential of the group (Mithun, 1983). It is the extent of home teaching of tribal ways, values and cultural norms that gives a child firm ethnic roots. Emphasis in teaching was placed on possession of private knowledge. This "guarded knowledge" of family geneologies and family successes

revealed family greatness; instruction in practical matters, such as how to quest for the right kind of guardian spirit and knowledge required for occupational success. All were taught by the child's grandparents (Patterson, 1962). The teachings formed the base of ethnic identity and affected culture change processes of the people (Miller, 1979; Mithun, 1983).

In early life, the parents, grandparents or caregivers had the task of directing the behavioral development of the child toward normative socially valued goals (LeVine, 1982). They did so by acting as mediator between the individual's behavior and sociocultural environmental norms of behavior (Lewis, 1980). Adult and parental behavior was subsequently determined by many environmental forces: available information, social pressures (e.g. culture change), constraints (e.g. economic or legislated), past experiences, beliefs, values, and life situations (e.g. work, marital relationships) (LeVine, 1982). These forces influenced the parent's definition of their role as mediators of environmental norms and the environmental information that is passed on to the child to be integrated into her personality (Levine, 1982; Red Horse, 1980). The role of mediator remains an important function of todays Native families.

Enculturation - Socialization - Education

From the viewpoint of anthropologists, the concept of enculturation rather than socialization is often preferred because it explicitly brings to mind the notion of acquiring, incorporating, or internalizing culture throughout life and especially at critical stages of the

life cycle. The process of enculturation requires various levels of complexity to be mastered throughout the lifespan. The simplest is an absorptive process, whereby an individual internalizes cultural patterns in a holistic pervasive fashion. To be successful this process requires an intact and stable, culturally determined environment (LeVine, 1982). Observation, imitation, reward and punishment are facilitating mechanisms for absorption. For the childbearing woman to absorb the appropriate cultural expectations, accessible female role models throughout her life would be important.

At a somewhat more complex level, enculturation is considered to be conceptually based in communication and information theory. Culture is communicated in implicit and explicit messages, in behaviors or action and words (Mead, 1964). It is assumed that a stable culture provides mutually consistent messages in the diverse environment of messages to which individuals are normally exposed (LeVine, 1982). But when an ethnic group is undergoing culture change, it is unclear how enculturation by communication and transmission of information takes place. How does a Native woman learn of the cultural expectations of childbearing when she has been formally educated in a Native residential school or non-Native public school and lives on an urban reserve which relies to a great extent on the social and economic services of the dominant society?

A considerably more complex view of the enculturation process acknowledges that individuals acquire cultural beliefs and categories of thought but within the limits set by sequences of cognitive development common to all humans (LeVine, 1982). Specific teachings and social experiences

are the means of transmitting cultural patterns throughout one's lifespan, including transitional stages of the life-style such as childbearing. What is learned will depend upon one's cognitive ability and readiness. Many authors have identified childbearing, easpecially the first pregnancy, as a heightened time for readiness and motivation to learn (Jessner, Weigert and Foy, 1970; LeMasters, 1965; Auvenshine and Enriquex, 1985).

Childbearing and the Family

Behavior patterns associated with childbearing are subject to family network influences.

> My grandmothers didn't usually learn about childbirth until they were ready to have their first children. I was raised this way, too, and it is one of the things about our customs that I have never understood... as soon as my grandmothers of the past knew they were pregnant, they slowed down their work and were forbidden to do many things. If it was a first pregnancy then the mother-to-be was given advice by an older woman with more experience, often a sister-in-law or the mother-in-law (Hungry Wolf, 1982:190).

Newman (1969) attempted to shed light on one means by which women are influenced by the past in the childbearing period. She investigated the prevalence, meaning and content of "Old Wives' Tales" because of their venerable tradition in folklore related to knowledge and beliefs of particular interest to women. Despite the pejorative connotation they have acquired of late, old wives' tales have not disappeared, nor are they dysfunctional. Newman found that the stereotypic communication style of Old Wives' Tales had remained a viable means of conveying information to the uninitiated. They may be considered as

ritual behavior, since communication of the pregnancy beliefs takes on the cultural meaning of defining the status and anticipated role of the expectant mother (Newman, 1969). The Old Wives' Tales are generally transmitted at the time of pregnancy, especially during the woman's first experience.

The family interactions and descriptions of roles of various family members are part of a total family process: a process of communication. From a symbolic interactionist perspective, this communication must be understood from two points of view: that of the intention of the speaker and that of interpretation by the recipient. When the interaction is of a traditional nature, Newman (1969) states that there is a historical dimension added. That is, family communication attains a standardized cultural meaning, a ritual behavior, referring to a wider context than the immediate communicants. It brings with it standards and beliefs, generally expressed as admonitions by others to the particular family member. The social context of interactions for the pregnant woman requires the person expressing the belief to be female and older than her. Because communication of pregnancy beliefs is ritual action on the part of the speaker, no formalized response is required by the childbearing woman. She is acted upon by the older woman. Newman (1969) hypothesizes that the intention and cultural meaning of the communication is to symbolize the status of pregnancy and the expectancy of motherhood, rather than to communicate useful instructions. The interpretation given to that communication by the recipient - whether it is believed or not, whether the behavior is modified or not - is irrelevant to its cultural meaning. This may help explain why some reiterated beliefs

and "Old Wive's Tales" do not result in congruent behavior in Native families. Respect for the elder person would require one to listen and not contradict, but the permissive approach to individual autonomy would not require adherence to the teaching. The strength of the family lies in its ability to communicate these beliefs about pregnancy, as they remind the pregnant woman and society of her responsibility and her transitional state.

Research Among Native Families

Except for the occasional documented testimonial from Native women and a few anthropological references there is little known about the influences of either the traditional or contemporary cultural environment on Native childbearing women. Barnett (1939) identified a few specific practices among the Northwest Coast Natives but did not provide the context within which these behaviors occurred or were transmitted. No mention was made of values or beliefs or the role of the family. Red Horse (1980) states that concepts of respect, generosity and harmony, Indian "life themes", are reflected through the survival and reigning influence of family patterns in Indian communities. The Native family is the cultural environment for community and family members. Because these are integrated with spiritual aspects, tribal-specific research designs are required (Red Horse, 1980). He emphasizes that mental health research related to the culturally distinct Indian family life is lacking.

Family Strengths

The family is not only influential in the deviant and

health-depleting behavior of drinking, it is also a source of strength in enculturation. Vincent (1984) in a presentation to a National Native Nurses Workshop suggested that although one must search for the root of the problems in the family, more importantly it is in the family that one will find the solution. Many Native families utilize the extended family to fill many roles of teaching the young people family responsibilities, cultural values, and personal skills. One of the significant traditional mental health strengths of the family that is being utilized less today is the encouragement, support and teaching from a family that includes aunts, uncles, grandmothers, grandfathers and cousins (Ryan, 1980). The description of this strength is congruent with the concept of social support as defined by Cobb (1976). Thus one of the major strengths of the Native family network is its ability to fulfill a social support function.

Manson (1979) considers that the way in which kinship relations are described is a distinct family strength because each individual is aware of her responsibility to the family network. These role expectations and responsibilities are often described through long stories of the past, recounted by parents and grandparents in intimate family settings. Pennier, a Coast Salish Native reminisces about his childhood days.

> At night he (grandfather) used to tell us long stories of the past...if I was smarter I would have listened a lot harder and learned a lot more, but of course I was still quite young...I guess that was when I started to be proud I was an Indian... (Pennier, 1972:17-18).

The lessons he learned were from stories, personal validation of beliefs and values, myths about man-

environment relationships and allegorical accounts of the Native way of life. Storm (1972) states that stories are often allegorical in form and need to be understood symbolically through one's own powers, reflections and seekings. This leads to learning to see through the eyes of others and share their perceptions.

> Whenever we hear a story, it is as if we were phsycially walking down a particular path that it has created for us. Everything we perceive upon this path or around becomes part of our experience, both individually and collectively (Storm, 1972:17)

The roles defined by family and tribe are thus passed down from generation to generation so as to continue the functioning of the Native family in the community. The roles for older men and women in the extended family served to enhance their status and to strengthen the family. The older woman's role was that of parent substitute within the family system, while for the man it was one of decision-making (Ryan, 1980). When these roles are stable, they serve to strengthen the function of the family as a social unit and provide a potential and significant source in coping with the problems of today's society.

Lewis (1980) writes about the strengths of the Native family: strengths which include supportive helping systems, spiritual quality of cooperation and being in rhythm with the earth, religious orientation and personal relationships built on respect. To this list should be added the communication of traditional values, beliefs, and ritual behavior. The family, as a mediating structure, provides meaning and identity to one's personal life and ensures that the larger social institutions do not lose connection with personal meanings (Levin and Idler, 1981). It is

parents and grandparents who decide how to organize relations between environments and children. As a mediating structure, the family network has the obligation to provide stability to the private sphere of the individual (from whence self-concept and esteem come) and to allow a variety of roles to be tried in order to fulfill socio-cultural expectations: a source of ethnic identity, alleviating anomie (Levin and Adler, 1981).

The individual's own meaning is developed through shared values, world view, and experience with the mediating structure. How the Native family network acts as a mediating structure for its members, establishing an environment for health behaviors, transmitting specific values and beliefs about lifestyle behaviors and providing health care related to childbearing experiences is unclear. Transmission of values and beliefs may be accomplished in a variety of mediums: myths, legends, story-telling, vision quests, disciplines, Old Wives' Tales, games and sports, and even dancing (Storm, 1972; Hungry Wolf, 1982; Terrell and Terrell, 1976; Newman, 1969; Vincent, 1984). Transmission of knowledge and understanding

> ...flowed gently through the family unit. There were no terms to define this progression. It was just plain everyday living (Vincent, 1984).

Because family transactions occur within a community milieu, family network structure must mediate and influence individual behavior patterns (Red Horse, Lewis, Feit and Decker, 1978). This is important for professionals to understand so that variant perceptions and mislabelling can be avoided. Normal behavioral transactions within the family network environment may appear bizarre to an outside observer, but be culturally appropriate to the members.

Red Horse and colleagues (1978) note that continually reinforced and enduring relational roles are evidence of the retention and transmission of cultural attributes. Grandparents, and even unrelated elders, retain official and symbolic leadership in family communities. Official leadership is characterized by a close proximity of grandparents to family. Children actively seek daily contact with natural or adopted grandparents and grandparents monitor parental behavior. The norm-setting standards of the grandparents are seldom ignored. They often serve as a major instrument for accountability; though enforcement of values, standards and expectations are established which maintain group solidarity (Red Horse, et al, 1978). Extended family networks remain as a constant, regardless of family lifestyle patterns, and are very important to the Northwest Coast Native peoples.

Alcohol Use

History of Use

The use and abuse of alcohol has been closely associated with the Native way of life, feelings of well-being, illness experiences and accidental deaths. A review of the history of Indian drinking reveals how rapidly alcohol abuse has become a problem and how intimately it is connected with the collapse of many Indian cultures. Some Native peoples would say that it was the collapse that led to alcohol abuse in many Nations (Wilson, 1985).

Despite scattered use of fermented beverages by Indians in the Southwest and perhaps the Iroquois, alcohol was unknown to most North American peoples before contact with

Europeans (Levy and Kunitz, 1974). The initial reaction to alcohol was positive and its effects were consonant with the precontact notion that spiritual experiences were valued (MacAndrew and Edgerton, 1979). To the Iroquois a drunken trance was regarded as a genuine metaphysical revelation. Lowering of inhibitions and violence were rarely seen in the first years of alcohol use (Carpenter, 1959). Gradually a more uniform pattern of drinking began to emerge which included boisterousness, agressiveness, violence and drinking until passing out (Winkler, 1968). Traders encouraged their Indian clients to drink quickly and heavily so that Indians could not drive hard bargains (MacAndrew and Edgerton, 1969). By the 1850's precontact social organization, economies and political and spiritual values were becoming seriously disorganized for many Indian tribal groups. Traditional means of survival were no longer possible and the federal reservation system promoted dependency and hopelessness (Heath, 1964). Throughout this deterioration process and despite the illegality of drinking between 1880's and 1950's, Indian peoples continued to drink at an alarming rate. Though the federal ban on sale of alcohol was lifted in the 1950's, some tribal councils have elected to continue, or reinstitute, the prohibition on their own reserves.

The past attempts at assimilating the Native peoples into the Euro-Canadian society by prohibiting the practice and transmission of their cultural values and beliefs has not been entirely successful in Canada. It is more likely that the pattern of culture change has been integration; whereby the Native peoples have retained much of their cultural heritage, while at the same time taking on a variety of behaviors of the Euro-Candian society. Graves (1967) notes

that among Indians in the Southwestern United States of America there is a great range of individual variation within the ethnic group, both for the degree of acculturation and the results it creates. The results were similar for men and women, but there were sex differences in the extent of drinking and social deviance (e.g. traffic violations, civil suits, violations of game laws). Relatively low rates of drinking and deviant behavior tended to occur **only** among those who were both acculturated and had a job that provided them with access to their new goals. High rates of drinking and deviant behavior were found among unacculturated Indians **regardless** of their degree of economic access (Graves, 1967).

The custom of drinking alcoholic beverages is viewed as persistent, easily diffused and widely pervasive in known cultural groups (Bacon, 1976). Among Native peoples it is considered a major public health and community mental health problem - a problem that is increasing (Brod, 1975). It is a complex social behavior that is culturally regulated. The use, function and meaning of alcohol and drinking are influenced by the cultural context and must be studied holistically from a number of different perspectives. Lemert (1956) concludes from his study of North West Coast Natives that no one hypothesis is sufficient for the complexities of the situation. Cultural conservatism, political consciousness, anomie, reaction to crisis and patterning, as affected by cultural diffusion of drinking behavior, interclan rivalry, stereotypes and the system of social control, all operate significantly in Natives' drinking. He also suggests that family environment and interaction are critical areas for investigation.

Problem Drinking

The term "problem drinking", rather than alcoholism, is more accurate in describing drinking amongst the Native people. When heavy drinking is the norm, it is misleading and difficult to classify individuals as alcoholic. Comparing rates of alcoholism in different cultures is often confusing and erroneous without an emic perspective (Bales, 1946; Brod, 1975; Leland, 1976). It is necessary to differentiate the degree to which alcohol is used and the degree to which it creates problems in the particular culture. Situations may be created and maintained which influence the rates of alcoholism, the attitudes towards drinking that the culture produces in its members, the degree to which acute needs for readjustment are required, and possibilities for subsequent gratification.

Although there are Native alcoholics with physiological dependence, many more experience other problems associated with the use of alcohol. The health issue is not in itself peculiar to the Native peoples. No proven physiological difference exists between Natives and non-Natives which causes heavy drinking. There is some controversial research which questions the assumption that among Native and white men comparable amounts of alcohol per unit of body weight are required to achieve intoxicating blood levels. Native Indians are supposed to metabolize alcohol by a different pathway and at a significantly slower rate than Caucasians (Fenna, Schaefer and Gilbert, 1972). The possibility of genetic linkage to metabolism and sensitivity and the results of the studies must be interpreted with caution however, since the health status of the two

groups was not comparable at the time of the study. The evidence is equivocal and too limited for valid conclusions according to Schaefer (1981).

Wilson (personal communication, 1985) suggests, based on his extensive work with his Native peoples and their use of alcohol, that there are several types of drinkers associated with different causes of the problem.

1. A Native who likes to drink and who lives in the city or village where sanctions against such behavior are non-existent, is doing what he/she enjoys. "Such a drinker is simply hooked on pleasure" (Wilson, 1985), without the necessary sacred and social controls (Thomas, 1981).

2. A Native whose social life is organized around drinking most frequently lives in a city where Native bars are the only source of social life. Similar to other Native men and women, drinking occurs in peer groups as opposed to solidarity situations. Comraderie is important, with pressure to drink coming from friends (Ferguson, 1968; Leland, 1978).

3. Some Natives drink in order to overcome dull feelings of inadequacy: feelings rooted in being a Native. Their excessive use of alcohol represents the product of a variety of historical and cultural factors screened through an individual personal psychology. Drunkenness may provide a short-cut gratification by providing fantasy solutions to culture-bound problems (Brod, 1975).

4. A young educated Native may feel culturally alienated: closed off and cut-off from social life after an institutionalized school experience. He/she drinks in order to "come out" and have some kind of genuine interpersonal relationships. Thomas (1981) proposes that drinking problems arise because tradition has been weakened, relationships between kin disturbed and moral prestige of the elderly eroded.

5. A child of a Native couple who drink heavily and neglect their parental role may be shunted off on an already overburdened relative. This child, who grows up seeing drinking that is nearly always excessive, will come to feel that this is the only way to drink. The childhood experience may engender a sense of being unwanted and unworthy of love. Drinking is a means to bear the pain (Swanson, Bratude and Brown, 1971). The family and individual escalating cycle of drinking can be interrupted, however. Leland (1978) found that many Native women who were described as "once in a while" or moderate drinkers matured out of drinking; the change is frequently associated with the exigencies of family responsibilities or being "in the family way". Childbearing and alcohol use behaviors may have reciprocal influences.

6. Lastly, there is the reserve Native who drinks in order to overcome the sheer boredom of reserve life. "There are few stimulating activities, few facilities and very few Natives willing to advocate other types of activities" (Wilson,

1985). A Native person, young or old, who has no great desire for drunken parties, often ends up attending because there is nothing else to do. Some of the women in Leland's study (1978) used drinking as a means to spend more time in male company, rather than as an end in itself.

Native Women and Alcohol Use

Schuckit and Morrissey (1976) have described the "middle and upper class" white woman drinker as one who drinks at home alone, hides her drinking with the support of her husband, has relatively few social problems as a result of drinking, and is rarely seen in bars. This description is now considered classic but we know almost nothing about alcohol use among Indian women except that it might be a problem of some proportion. We do not know the characteristics of these women as they are underrepresented or completely unrepresented in the reported studies. Several authors make brief mention of American Indian women drinkers but do not outline a pattern of drinking or other related biographic characteristics (Kunitz and Levy, 1971; Hamer, 1965; Brod, 1975; Mail and McDonald, 1977; Lemert, 1954; Shore, Kinzie, Hampson and Pattison, 1973; Ferguson, 1968; Hurt and Brown, 1965).

In a study done by Walker and colleagues (1978) on female alcohol abusers admitted to a county detoxification center in the Pacific Northwest, differences were found between Native and non-Native women characteristics. Native women reported their occupations as predominantly blue collar while Caucasions were divided between white and blue collar. Native women reported a lower percentage employed,

as well as a lower monthly income. The Indian women in this study tended to be younger, reared fewer years by their parents, migrant and thus apart from family and social supports, living in missions and on skid row, living and eating with friends, less well educated, having dropped out of school to help their families financially, more likely to have been incarcerated, of a younger age when they began to drink and first became drunk, drinking in public gregarious groups and preferring group drinking, having had less mental health treatment, and having sisters who drink. These characteristics are congruent with those found for both male and female Natives in two Vancouver-based studies (Mears, et al, 1981; Lin, Tardiff, Donetz and Garesky, 1978).

However, not all Native women, or for that matter Native peoples, who consume alcohol are examples of the "drunken Indian" stereotype. Although there are variations both among Native groups and within their groups, there are a number of common norms and expectations of drinking behavior. Response of tribes to heavy alcohol use is seen as a response to the environment which includes reserve life, federal administration of Indian Affairs, discrediting and attack of Native religions and cultures and schools designed to "de-Indianize" the children. Westermeyer (1974) examined the myths and realities of the drunken Indian stereotype and reviewed the data on their alcohol usage. His findings substantiate the concept of variability among and within the tribes, both for patterns of alcohol use and related problems. Leland (1978) concluded from her pioneering study of Native Women in a Nevada settlement that the indirect effects of alcohol on women greatly overshadowed the direct ones and that the women's

methods for dealing with the effects of men's alcohol use probably deserved even more attention than women's drinking. The majority of women she studied perceived that women of their tribe seldom drank and most who did were described as "being able to handle it". Whether this is typical of Native women's drinking behavior or not has yet to be validated. The stereotyping of the Indian as a drunkard by the white man and the Indian's response thereto has been studied either by describing the integrative aspect as a cultural pattern or speculating about the positive function of drinking, rather than giving attention to developing a theoretical framework to understand the behavior or role pattern as a problem. Some researchers have found that the Native peoples frequently live up to the stereotypic image held of the "drunken Indian", yet adamantly retain a high degree of ethnic identity (Heath, 1958; 1964; Devereux, 1948; Lemert, 1954; Honigman and Honigman, 1945). There have been few analyses of these situations, but rather a lot of individual interpretation over the years.

Drinking Patterns

It is generally accepted that practically all drinking is a social activity for Natives in either spontaneous or planned parties. The spontaneous ones are generally small group affairs, whereas the planned parties for weddings and birthdays may expand to include the whole community (Homer, 1965). Drinking is a major form of recreation and often a means of gaining courage and overcoming shyness. The pattern developing from this appears to have been one of family drinking, with emphasis on sharing among members and friends.

To say that the issue of Native drinking and understanding the behavior is controversial is an understatement. A number of theories have been proposed to explain the association between acculturation and behavioral outcomes. Two major approaches to understanding Native peoples' use of alcohol have emerged.

The first approach views the excessive use of alcohol by Native peoples as the result of their position in the dominant society and the pyschosocial concomitants of that position (Graves, 1967; 1970; Jessor, Graves, Hanson & Jessor, 1968). According to this theory, being in a disadvantaged position in society promotes feelings of alienation, deprivation, and frustration in attempts to reach goals. A transitional state of acculturation exaccerbates a negative psychological state, resulting in excessive, abusive drinking. Within this theoretical scheme, drinking is considered a deviant behavior in response to social expectations. The higher incidence of social-problem behavior in acculturating minority groups may be due to inadequate means of attaining a set of new goals (Merton, 1959). Chance (1960) and Berreman (1956) found that communities where members had adequate economic opportunities for the attainment of their newly acquired wants, symptoms of social and psychological disorganization were minimal, despite rapid change. However, variation within groups suggests that psychological characteristics and individual perception of the situation of acculturation must also be considered (Graves, 1967; Forchuk, 1984). Ethnic identity is an important variable to consider in this approach.

An alternative approach views Indian alcohol abuse within the cultural context of tribal societies. Levy and Kunitz (1974), focussing primarily upon reservation dwelling Navajo, have argued that the cultural legacy -- the way that Navajo tribal culture has dealt with alcohol since its introduction several decades age --- is the critical factor in explaining Indian drinking. In this view, drinking behavior is based upon normative processes of peer group drinking rather than upon psychosocial problems related to conflict, alienation or anomie. Agreeing that Indians occupy a disadvantaged position in American society, Levy and Kunitz (1974) nevertheless reject the view that alcohol abuse among Indians is a retreatist response to social and economic deprivation within the larger society.

Homer (1965) concluded that lack of social controls, personality attributes and control of interpersonal aggressiveness made drinking an acceptable innovation in Native culture. Littman (1970) suggested that reasons for excessive alcohol use among Native peoples in transition reflected both sociocultural and psychological factors. The conclusion he drew from his study among Native Indians in Chicago indicated that:

> 1) The Native peoples, who drank heavily had attitudes toward illness that included resignation; belief in magical infliction and witchcraft, self-destructive behavior and expressed violence; 2) Non-Natives described Native drinkers negatively as being emotionally restrained and inhibited; permissive in childbearing, stoic and passive, unconscious of time; 3) Native peoples experience religion as a way of life rather than a segment of

> life, as other Americans did. Drinking was not perceived as an incompatible behavior with their spiritual value orientation; and 4) The Native person abusing alcohol, was alienated from her own culture and left only with impersonal agencies and bureaucracy interactions. Which came first, the drinking or alienation is not known. These findings are similar to those Lin (1978) and Mears (1981) and their colleagues found among Canadian Indians in Vancouver.

Personality variables of self-concept and self-esteem may mediate the association between acculturation, limited economic access, and excessive alcohol use (Forchuck, 1984; Pennock and Poudier, 1978; Wallace, 1977). Feelings of deprivation and alienation are associated with drinking to solve problems of incongruence between acculturation and economic access to goals. Acculturated Native peoples with limited access to rewards of the larger society report significantly stronger feelings of relative deprivation, significantly greater alienation and significantly more psychological problem-solving reasons for drinking than those holding down jobs (Graves, 1967; Heath, 1965). Homer (1965) found that the Natives' willingness to project the responsibility for undesirable characteristics onto others was a trait usually associated with alcoholism in industrial societies. Avoidance of self-responsibility may be a way to cope with the dilemma of dissonance engendered by the acculturation process.

Although the outcomes of drinking behavior are shaped by physiology, nutrition and prior life experiences, it is patterns of beliefs and behavior that affect the cultural

groups' identification of drinking problems, labelling of "excessive drinking" and drinking norms (who, what, where, when and how much one should drink). The Native perception of the Native alcohol problem suggests that drinking may be a learned behavior, based on attitudes and values (Heath, 1981). It may be of some significance that the introduction of alcohol to the Indian was largely assumed by soldiers, trappers, traders and frontiersmen, members of the white population whose characteristic drinking patterns were, by and large, rated unacceptable by the majority society of their day. They were, in the beginning, the only ones available to provide models of drinking behavior.

Today, there is a tendency for Native peoples to feel that excessive drinking, as learned from early role models, is a part of the present way of life. The drinking style does not represent a radical change from traditional customs. In their extensive ethnohistorical study of alcohol introduction and use among Indians of the Northwest Coast, Amoss and Boyd (1980) describe the impact that behavior at feasts had on drinking behavior. At formal Potlatches, in honor to himself and his host, as much as possible was consumed. Traditionally, food was shared and eaten as it was available. It was not harboured for later use in solitude. Sharing and taking advantage of the availability were characteristics of the West Coast Native's food practices. This pattern of consumption was reflected in drinking. The supply of alcohol was unpredictable, reminiscent of the food supply situation which resulted in episodic, but heavy drinking.

Traditionally Native people in many areas have shared goods, especially food and drink. Today, individuals have

tremendous peer pressure applied nearly every weekend or any occasion when liquor is available. They face a problem if they do not drink to the best of their ability until the last drop of liquor has gone. A Native trying to become a moderate drinker or trying to give up drinking altogether is prevented from doing so by social pressure according to Wilson (1985). If successful in abstaining, the Native person faces the dissonant dilemma of a non- conformist, a social outcast - reflecting on both self-concept and ethnic identity.

The question arises: what happens to those not assimilating, but retaining an orientation to traditional goals through integration? Psychological pressures of alienation and deprivation may be equally high as contact situations often result in a breakdown in the means for the achievement of traditional goals (Gillin, 1942; Homer, 1965). When there is limited access to attaining traditional goals and maintaining ethnic identity, socio-psychological disorganization, including heavy drinking and related deviant behavior, is apt to occur (Graves, 1967).

> This may also help to explain why during previous centuries it was often the acculturated Indians, orienting toward new and relatively unattainable goals, who displayed the greater drinking problems, in contrast to the Indians who retained their orientation toward a traditional...culture. (Graves, 1967: 320).

Today, resurgence of Native ways of life and ceremonials, especially on the reserves, is associated with abstinence, at least during the season for winter ceremonials and summer training and pulling in canoe racing (Jilek, 1977; 1978) and with increased emphasis on the importance of the

family network (Speck and Attneave, 1973; Kekahbah and Wood, 1980; Red Horse, 1980). However, alcohol-related problems are still prevalent among all age groups but only when the family or band has defined the situation as a problem has action been taken. In treatment, the family network has proven to be the critical point of intervention for successful control of drinking behavior. The traditional role of the Native family has not lost its saliency for members with drinking problems, nor has it become less important for its advocacy, support or teaching functions for all family members.

Alcohol use and the Family

Considerably more attention has been paid to the transactions between family and environment and the peoples' drinking behavior. The research related to mechanisms of transmission of alcohol abuse has not been specific to the Native context, however. Nor has it been entirely elucidative. Several investigators have considered the contribution of the genetic component in the general population, but have been unable to explain why some family members with the same genetic inheritance develop alcoholism and others do not (Goodwin, 1979; Schuckit, M. and Rayses, V., 1978; Murray and Gurling, 1980; Pendagast, 1981). Unanswered questions of host vulnerability and host resistance remain. Other investigators have attempted to identify racial differences in reaction to alcohol consumption, but unequivocal results are not forthcoming (Axelrod, 1974; Bacon, 1976; Brod, 1975; Madsen, 1974; Wolff, 1977).

Another approach to understanding the multigenerational transmission of alcohol abuse may be to consider it as a sociocultural multigenerational enculturation process, or the transmission of family patterns which contribute to the onset of alcohol abuse and the exacerbations and relapses connected with alcoholic drinking (Abalon, 1973; Roman, 1971; Reynolds, O'Leary and Walker, 1982). Components of this process include patterns of spousal conflict, spousal dysfunction and projection of family drinking patterns to children (Davis, Berenson, Steinglass and Davis, 1974; Shore, 1981). Although research among Native families is lacking, persistent patterns among white families have been found and explained by (1) unsatisfactory relationships to parents during the childhood formative years which contribute to a sense of personal inadequacy and lack of self-worth (Boothroyd, 1980), (2) lack of family cohesion (Moos, 1979), (3) family conflict (Moos and Moos, 1976) and (4) difficulty maintaining family homeostasis (Julius and Papp, 1981). Distorted self-concepts, poor self-esteem and lack of ethnic identity are transaction variables in the vicious cycle of the development and maintenance of drinking behavior that is abusive or problematic. Whether or not these explanations are applicable to Northwest Coast Indians has not been investigated or reported.

While studying the drinking behavior of a tribe of Native women, Leland (1978) found that alcohol played an important direct role in the lives of only about 25% of the women, while for the remaining 75%, the primary influence of alcohol was indirect. The fact that "...drinking is the main focus in the battle of the sexes at the Indian settlement" (Leland, 1978:108) required the development of family strategies for adjusting to it. These strategies included

complete capitulation or resignation as an attempt to maintain family cohesion, surveillance of drinking and other deviant behavior which escalated spousal conflict and drinking with the family member. The rarest strategy used to cope with drinking in the family was an agressive approach - arguing, complaining, nagging. This is consistent with the Native value system. Alcohol abuse may be viewed, not as a result of one person's pathology but, as a result of interaction among all Native family members in a behavior pattern that stabilizes a family's social, cultural, emotional and physical life.

Haer (1955) found that drinking behavior and influences on drinking behavior were not the products of random choices by individuals but rather varied according to their cleavages to the peculiar social norms and social group. Drinking patterns for white adults were strongly related to those of friends, then spouse, then father and finally mother. Haer's (1955) data suggested that the behavior of contemporaries, friends and spouse were much more potent in establishing drinking practices than the behavior of the previous generation. However, the families from which his sample were drawn were not extended families, nor were the individuals Native peoples. The findings did not address the issue of ethnicity.

Researchers have also been interested in sex differences in drinking behaviors. They have found that women, in general, seem to have the greatest dependence on the norms of their spouse, somewhat less dependence on friends and much less on parents, whereas males rely equally on all three (Haer, 1955). The differences in the degree of association between the drinking patterns of males and

females and their parents may suggest that males are most influenced by the father, and females by both parents to about the same degree. Whether this is true of men and women today is unknown. Presumably changes would have occurred along with the changing quality of egalitarianism of roles. Women who drink, however, do tend to have experienced more emotional trauma in their past lives, especially before the age of 10, and report more current stressful events than do males (Boothroyd, 1980). Making comparisons between male and female patterns is difficult because it is socially more acceptable for men to drink in public and acknowledge an alcohol problem, whereas for women it is more acceptable to complain of depression and drink in isolation (Beckman, 1975; Corrigan, 1980; Fine, 1978; Weissman and Klerman, 1977).

The urban-rural background of individuals and families has been identified as a significant variable in determining the sources of influence on drinking patterns (Haer, 1955). Those with an urban background have been found to have a drinking pattern that had a high degree of relationship with father, friends and spouse. In the rural group, the closest relationship was found in association with friends, then spouse and finally parents. How these findings might be related to Native peoples living on reserves in either urban or rural settings is unknown. If geographic isolation, along with slower dissemination or integration of new social norms, are determining factors in the urban-rural differences, it might be reasonable to assume that the rural patterns of influences would be most closely associated with life on the reservation, but that Native women living on an urban reserve might be most influenced by family and then friends.

Although most of the family research in alcohol abuse has focussed on the white population, Leland's (1976) review of anecdotal references determined some significant variables in the Native family context. Some of these were family accounts of drunken aggression often aimed at wives, sexual assault, frequent arrests of husbands, extended bouts, severe health problems associated with alcohol use and countless other hardships. Although severely strained relations with families were evident in the reports, this situation was unlikely to result in broken marriages. Families stayed together putting up with the alcohol problems or joining in the drinking behavior.

Native People's Concerns: Education, Child Welfare, Health and Health Care

Both overt and covert attempts to force assimilation upon the Native peoples have occurred from the time of confederation until today. Euro-Canadians passed legislation which specifically prohibited cultural activities and disenfranchised certain individuals from ethnic membership. Less overt policies regarding the use of natural resources, land and social-recreational services made it difficult, and at times impossible, for the Native peoples to maintain and teach their traditional practices for subsistence and communal living. The Indian medicine man (Shaman), herbalist and midwife were discouraged from practicing and tended to be denigrated by non-Native society, even though they were usually the only "medical professionals" available. Much of their knowledge and skill has now been lost.

The result of these attempts at assimilation not only tended to erect barriers to effective communication between

the Native and the non-Native but also in the process to foster feelings of inferiority among the Native peoples which has left them ill-equipped to deal with the demands of Canadian life. Three historical issues remain salient concerns of the Native peoples today, education, child welfare and health and health care. Both educational and child welfare policies and experiences are perceived by the Native peoples as having a profound influence on their feeling of well-being, health status and use of the health care system. The past experiences of today's parents and grandparents in residential school, boarding homes or non-native foster care are described by the Natives as deculturation experiences resulting in "culture poor" people. Since feelings of well-being, states of health and health seeking behavior are socio-cultural definitions, educational and child welfare experiences are significant variables to understanding childbearing issues.

Education

Under the guise of providing education for the Native children, missionary residential schools separated children from their parents, prohibited them from speaking their Native language and sharing cultural beliefs and values and treated them as pagans to be converted to Christianity. No trace of "Indianness" was to be left. The motivation behind the development of Indian Schools was religious conversion and rapid assimilation (Cardinal, 1969). Prior to 1950, missionaries were responsible for educating Indian children. Thereafter denominational schools were amalagamated or taken over by the federal government, Department of Indian Affairs. Most of the schools were far removed from the reservation since the authorities were in agree-

ment that a complete break with the home environment was essential if the Indians were to become effective citizens (Bullough & Bullough, 1972).

However, many of the skills the Indians were taught in the school had no application in the life they would lead when they returned home to the reserve. Compared to the traditional teachings and Native lifestyle, education in the residential schools was strikingly foreign. Traditionally, children of each sex were trained to perform the various functions that would be expected of them once they assumed their eventual place in the social structure. Generally the band elders, or wise men, in conjunction with the parents, were responsible for the value orientation of the child.

> In the old days, the Indian people had their own system of education. Although the system was entirely informal and varied from tribe to tribe or location to location, it had one great factor going for it - it worked. The Indian method, entirely pragmatic, was designed to prepare the child for whatever way of life he was to lead - hunter, fisherman, warrier, chief, medicine man or wife and mother (Cardinal, 1969:52).

In the past when all of the social institutions of one's society had been intact, the child was able to become part of, and relate to, a stable social system. Her identity was never a problem (Cardinal, 1969; Attneave, 1979). Her education fitted her to her society; she knew who she was and how she related to the world and the people about her. The arrival of the white man and missionaries brought into the Indian world different values, different concepts of life that disrupted the educational and religious institutions of the Indian. Residential school experiences posed a "no-win" situation. The student who did not adapt

to the routine at residential school was miserable while she was there, but those who did adapt successfully were miserable when they returned home to their families (Bullough & Bullough, 1972). Those who tried to be successful were at a disadvantage as they sought to hide their Indianness and lost their pride (Cardinal, 1969).

Penner (1983) concludes that external control of the education of Indian children has been destructive of Indian culture. It was believed that by removing Indian youth from their homes and placing them in captive environments, the heart and soul of Indian culture would be removed: a process of deculturizing the Indians. Specifically, in residential schools Indians were not permitted to speak their language, practice their religious beliefs or rituals, or have the opportunity to learn what it meant to be a self-actualized Indian. The Indian Homemakers of British Columbia gave witness to the Task Force on Indian Self-government by stating

> The effects of residential schools on this generation of parents must be taken into serious consideration since the parents of today were the generation of residential school children of yesterday. They're considered by their people as the lost generation (Penner, 1983:28).

Many Indian women retain deeply engrained memories of life in the residential schools where they were taught to reject all that was Indian. Mothers and grandmothers frequently expressed concern when their daughters returned after the first year. Some were not allowed to go back because they did not know the language or Indian way, only the non-Indian values (Cruickshank, 1969). Mothers today have less to teach their children today because of lack of common experience. This may hamper communication between mother

and daughter, with the generation gap taking on a cultural gap as well (Cruickshank, 1969).

Failure to relate the "new" education in any pragmatic way to Native lifestyles may contribute to many Native students' inability to appreciate the benefits of real education and lack of motivation to learn and stay in school. In Canada, less than 20% of Native students finish grade 12 (Canadian Education Association, 1984). The fact that many of the parents of Native Indian children have not continued their education beyond grade school (Demert, 1976) has implications today in terms of parental participation in and support of their children's education. This interruption of generational guidance and influence began a cyclical pattern of problems in formal and informal Native education with the inauguration of residential schools.

> Being schooled in one way and relearning what I was taught as I was growing up has caused much turmoil in me (Walker, 1980:43).

The reasons for the continual misunderstanding of Indian philosophy and psychology are difficult to come by. Even though civil servants and religious-educational leaders were often well educated people, they were usually not trained to understand or work in a culture other than their own (Fey & McNickle, 1959). The popular stereotype of cultural homogeniety of Indians meant that policies and their implementation failed to take into consideration the differences in customs that existed between tribes. This limited the relevancy of the educational attempt and ignored individual and ethnic identity.

Cardinal stated that

> Our identity, who we are; this is a basic question that must be settled if we are to progress. We must rebuild our structures of social and political leadership, demoralized and undermined for a hundred years by the Department of Indian Affairs; we must restore our family unit, shaken and shattered by the residential school systems; we must rebuild communications between the younger and older generations of our people. We must recognize that the negative images of Indianness are false; the Canadian government must recognize that assimilation, no matter what they call it, will never work. Both Indian and non-Indian must realize that there is a valid, long lasting Indian identity (Cardinal, 1969: 24-25).

While being concerned about the effects of residential schools, a study of Boarding Home Programs, an alternative for Indian high school students, was undertaken. These students were found to be in a less advantaged position than even Indian foster children in temporary care of child welfare agencies (Snider, 1969) or those previously in residential schools. The high school students experienced separation trauma and culture shock, loss of identity and loss family, kinship and community support with greater intensity. The program's emphasis on individualism was in opposition to the lineality value orientation of Indian culture and further engendered feelings of loneliness and homesickness. For future experiences, including childbearing and parenting, this loss of culture and family support is significant. Teachings, disciplines and instrumental and affective family support from extended members were interrupted and the woman was made to feel that she had to cope with the situation alone.

Several authors emphasize the influence of culture and socialization on the cognitive style of ethnic groups, which in turn influences the interpretations and perceptions of objects and concepts of the external world (Bagley, 1984: Morse, 1984). Early residential school experience has affected today's parents and would-be parents in a number of ways. Enshrinement of cultural values that exclusively reflect those of the dominant society have caused some Native peoples to internalize these values to such a degree that they are prepared to give up their children to white, middle class homes, so that their children will have a better chance to make it in the non-Native society. For others where acceptance has not been as complete, internal struggles have resulted in loss of some personal respect for Native approaches to traditional modes of life, and child care. This often results in confusion and value dilemmas. Many students of residential schools who question the validity of the values enforced upon them have ended up being apathetic and rejecting values of both Native and non-Native societies (Morse, 1984).

The educational situation that was created for the Native peoples may be likened to the conditions of anomie described by the French sociologist, Emile Durkheim (1951). Although Durkheim made his generalization on the basis of rapid social changes created by industrialization, the same generalizations would seem to apply to any society undergoing rapid social change whereby old norms lose their saliency. When they are not replaced with new functional rules, value and belief systems become unstable and conflictual. Durkheim stated that during a period of readjustment when people are unsure of themselves or torn

between conflicting sets of norms, social pathology such as suicide is common (Durkheim, 1951). Others have found a close association between being socio-economically disadvantaged and experiencing mental illness, especially depression and suicide (Brown & Harris, 1978; Weissman & Klerman, 1977; Warheit, Halzer & Arey, 1975; Warheit, Halzer & Schwab, 1973). According to recent health statistics, Native people are at significantly higher risks of experiencing violent deaths and attempting and/or committing suicide than the general population (Health and Welfare, 1982).

Since 1971 the Department of Indian Affairs has adopted a policy of Indian control of education, but Indian bands have discovered that their influence is still limited. The resources of the Indian community are called upon, but Indian control is limited, partially due to jurisdictional gaps in financial tuition arrangements. If provinces have accepted the responsibility to provide education services to status Indians, as is the case in British Columbia, then the major portion of the federal education budget of the Department of Indian Affairs goes to the provincial government. The bands receive little monies for operation and are subject to provincial educational policies.

Education is a central area in which Indian people wish to exercise jurisdiction in order to pursue their goals of producing healthy, proud and knowledgeable future generations. The "lost generation" of today's parents, deprived of their Indian heritage, confused about their value and belief systems and ignorant of many of the traditional teachings is of grave importance to the Native peoples. They feel that if the present generation of children is not

taught the Native culture, assimilation, rather than integration with retention of traditional cultural identity, will result. Burke and Sawyers (1984) have found that Native children's health and development status is significantly associated with the mother's degree of cultural change. Retention of cultural identity, values, beliefs and practices tended to be the most compatible with good health and developmental progress in children. Regardless of what effects the residential school experience had on children who are now in their childbearing years, there is a serious gap in their knowledge of, and experience with, their Native peoples' cultural beliefs, values and practices for daily living as well as childbearing.

Child Welfare

A second important area to Native survival is child welfare (Penner, 1983).

> The imposition of non-Indian views of child care, through the enforcement of provincial child welfare policies on reserves, has had tragic effects on Indian family life (Penner, 1983:31).

A recent study, "Native Children and the Child Welfare System" reveals that in 1955 approximately one percent of the children in the care of child welfare authorities in British Columbia were of Indian ancestry (Johnston, 1983). By 1964 this figure had risen to 34.2%, or five times the national average. Patrick Johnston, author of the study, referred to the practice as the 'sixties scoop'; provincial social workers would scoop children from reserves on the slightest pretext in order to 'save' them from what social

workers considered to be poor living conditions or parenting situations. The provincial authorities have been criticized for judging these conditions by non-Indian standards.

All the laws and regulations administered by the social welfare agencies and workers are based on culturally different values and a non-Indian concept of family and intra-family relationships. When these policies were applied to Indian communities conflicts rather than solutions were created. Conflicts were generated between the Native peoples and non-Native social workers and between Euro-Canadian and Native cultures: conflicts that hindered rather than helped child and family development.

The Native people have viewed the federal policies and practices which take children away from their parents and communities as means of assimilation (Penner, 1983).

> Each time an Indian child is spirited away from our reserves, family unity is being destroyed and we are being deprived of our future great leaders .... Indian children... have an inalienable right to keep their parents. They have an inherent right to retain their language and culture (Alberta Council of Treaty Women in Penner, 1983:32).

Removal of Native children from their families and community and placing them in a non-Native environment during the critical years of human growth and development deprives them of the opportunity to internalize a Native value and belief system and gain knowledge of the practices and customs. Among many Natives there are strong traditions surrounding family, childbearing and child-raising. For the apprehended child of the 1960's, as for

the residential school student, these traditions may be lost or unfamiliar as they now take on the role of parent. As parents they are faced with the dilemma of learning their own cultural past, while at the same time being expected to live and teach it.

A common theme among Canadian Indians is the saliency of their young people. Children are highly valued because they "are the hope and life-blood of our nations, and their removal strikes at the very heart of our culture and heritage" (Restigouche Band in Penner, 1983:33). The opportunity to express this value must be available to families and communities in practice as well as in teachings. Native autonomy in child care is one way to encourage appropriate transmission of cultural heritage from one generation to the next, so that healthy growth and development of children is encouraged. Both adults and parents, deprived of traditional knowledge, need a means of obtaining autonomy as they take on new roles.

Health and Health Care

The Native people's third area of policy concern is health and health care. They would like to have the power to establish priorities, coordinate the over-all planning, allow flexible arrangements for the delivery of services and control the process of health care (Penner, 1983). As with education and child welfare, the Native peoples perceive health and control of the health maintenance system as being critical to their cultural survival. By exercising control over these matters, Indian people could ensure that future generations are able to preserve and enjoy their culture and heritage.

Health

The shocking degree of ill-health among Indian people has been widely documented and referred to as the "tragedy of Indian ill-health". Although the federal medical care program for Indians and Inuit has been extensive, involving significant sums of money for health services, Indian health has not improved to a great extent (Berger, 1980, Begin, 1980). The Report of Advisory Commission on Indian and Inuit Health Constitution points out that "the reason is that so many of the causes of Indian ill-health lie beyond the fact of illness itself and the remedies lie beyond the mandate of MSB (Medical Services Branch)" (Berger, 1983:3). Wilson differentiates between the problems, manifestations and causes:

> The root problems in the health crisis of Native people are not poverty, unemployment, inadequate housing, alcohol and drug abuse. These are the outward manifestations, the symptoms of an unhealed wound dealt the Native people by the superimposition of an alien culture on the Native society. The loss of traditional food supplies, the loss of traditional approaches to health and healing, the entry and change onto Native land and waters by industry, the fragmentation of government responsibility, overcrowded reserves and a desperate housing situation, the loss of language and culture through an alien education systems, the loss of Native local economies are all factors which influence Native health.... The root cause of health problems has been the policy of the federal government during the past three generations of Native people, with regard to its responsibility for Native people of Canada. This policy resulted in the destruction of the extended family unit when the federal government dictated that all Native children be sent to residential school and given a 'proper education'. The effect, in three generations of Native people has been the

development of a Residential School Syndrome (Wilson, 1983: 1-2)

Wilson goes on to identify two other root causes of health problems to Native people. One has been the removal of Native children from the family unit to foster care. Another, more subtle cause is the acculturation of Native people in urban areas, with resulting ignorance of their culture and identity.

Significant differences are evident in the nature and types of causes of death between Natives and non-Natives. Fatal accidents, for example, are more than three times as common among Indians as among the rest of the population and are the leading cause of death (Health and Welfare, 1982). Further investigation into the accident rate shows that between the childbearing ages of 25 and 45 the fatalities are five times that of the comparable population. The accident statistics in part reflect such factors as unsafe vehicles, poor housing and unsafe working conditions, but they also indicate a much more serious sociocultural problem. The suicide rate is twice that of the national average, escalating among the younger group to six times that of the national average and the homicide rate is three times the national average (Wilson, 1983; Penner, 1983; Berger, 1980; Bullough & Bullough, 1972). Many of the deaths labelled suicide also seem to be self-destructive in nature and suggest that Native peoples are facing significantly important social problems.

For registered Indians the death rate in 1982 was 5.9/1000 population (Health and Welfare, 1982): for the general population in British Columbia it was 7.3/1000 population (Ministry of Health, 1982). This is reflective of a

younger aged population of the Native peoples, compared to that of the general population. Today Native peoples are much more likely to die from acute, but preventable causes than from chronic disease or old age. Accidents, poisoning and violence account for more deaths than any other cause for Native peoples of British Columbia (Health and Welfare, 1982): whereas the major causes of death for the general population are ischaemic heart disease, cerebrovascular disease and cancer (In Sickness and In Health, 1983). Of the 1500 fatal accidents experienced by registered Indians in British Columbia in 1982, 472 were alcohol related, with 433 occurring to adults in general and 6 to pregnant women (Health and Welfare, 1982). Deaths from cirrhosis of the liver, are more more than four times as common among Native compared to non-Native people (Berger, 1980; Penner, 1983).

With the exception of elderly people over 75 years old, death rates in all Indian age groups are at least twice the national average and death rates from accidents, poisoning and violence have continued to rise, whereas among all Canadians, death rates from these causes seem to have leveled off. In 1978 one out of every five violent Native deaths was a suicide (Begin, 1980), whereas for all Canadians, violent deaths usually occurred from motor vehicle accidents. Indian infant mortality rates remain nearly twice as high as the national average. Ranking rates of death and hospitalization for Indians and Canadians further indicates the underlying differences in health problems between the two groups. Indians in general suffer from diseases which are preventable and which are indicative of their poor social and economic living conditions (Begin, 1980).

Despite three decades of health education and improved access to health care, the stillbirth rate for Indians remains twice that of the population as a whole, and death of live-born infants in the first seven days is 1.8 times greater. Infants in the first 12 months have twice the death rate of those in the general population (Berger, 1980). Shifts in childbearing and childrearing practices, e.g. breast feeding to bottle feeding, appear to be associated with increases in gastrointestinal disease and middle ear infections (Berger, 1980). Poor diet resulting in malnutrition and nutrition deprivation during childbearing is associated with low birth weight infants, who are then more susceptible to health depleting events, handicaps, and death within their first year of life.

The birth rate among registered Indians in British Columbia has declined slightly in the past 10 years, but continues to remain higher than that for the total population of British Columbia: 23/1000 population Registered Indians versus 15.4/1000 population for the general population (Health and Welfare, 1982: Ministry of Health, 1982). Although Indians comprise approximately 2.4% of the total population in British Columbia, their births comprise 5.1% of the total births in the province and increase the provincial birth rate by 2.4% (Graham-Cumming, 1966). Sixty-one percent of the live births were to women between the ages of 20-29 years; 29% to women younger than 20 years of age, and 10% to women between 30 and 36 years of age (Health and Welfare, 1982). This birth distribution among ages is consistent with the age distribution of registered on-reserve Native peoples; and is similar to that of the accident rate by age (Health and Welfare, 1982).

As indicated in Chapter 1, there remains a large, but narrowing, discrepancy between the health status of Native peoples and that of the general population in Canada and British Columbia. According to a study done by Graham-Cumming in 1966 the Native population in Canada influenced the overall health status of Canadians disproportionately to its contribution to population increase. Although in 1966 Canadian Indians had the effect of increasing the population from 19,792,600 to 20,014,900 or by 1.1% and births from 379,014 to 387,710 or 2.3%, the influence on infant deaths was to increase the number from 8,504 to 8,960 or 5.4% and to increase the National Infant Mortality rate by 3.1% (Graham-Cumming, 1966). It is also apparent from persistent differences in life expectency and causes of death, that discrepencies in health status persist in similar proportions. This is particularly noticeable in the western provinces, including British Columbia, where the Indian population makes a greater significant contribution to all vital statistics (Graham-Cumming, 1966; Duff, 1964; Health and Welfare, 1982). The excess Indian deaths are related primarily to environmental and maternal socio-economic factors according to Gideon (1980).

Although the actual numbers of births and deaths per year have decreased since 1966, they have done so proportionately for the Native and general populations and the inequity between Native and non-Native rates remains almost constant. Perinatal and neonatal death rates are approximately 60% higher than the national rate and post-neonatal mortality is twice the national rate (Indian Affairs and Northern Development, 1980). The majority of neonatal deaths are attributable to immaturity and respiratory distress syndrome. Seven and a half percent of infants are

born with a birth weight of 2500 grams or less compared to 5.2% for the general population in British Columbia (Ministry of Health, 1982). In the past 10 years the infant death rate has been reduced from 41.9 to 21.4/1000 live births (1982) - an impressive feat - but still well above the 9.9/1000 live births for the province in general (Health and Welfare, 1982; Ministry of Health, 1982). Gideon (1980) found in his experience with American Native peoples that conditions which were found to be strongly associated with postneonatal mortality were maternal alcohol abuse, attempted suicides and physical trauma, along with low household income and adverse home environmental factors, such as lack of social consciousness or awareness.

Health Care

The health status of today's 300,000 status Indians has its basis in disease history, provision of medical and health care services, living conditions, and cultural changes (Berger, 1980). The Native peoples' state of health has been closely associated with their self esteem and relationship with non-Natives since the time of contact. In pre-Columbian times there may have been as many as one million Indians living in Canada. They were, by all accounts and on the basis of comtemporary criteria, a healthy race. Each community enjoyed pride, integration and dignity that came from independence and self-reliance, of living on the land. This manner of living necessitated close harmony with nature, and a system of hygiene and healing based upon its law.

> As Indian people we possessed a way of life that ensured our peak fitness and full physical, mental and spiritual development. The first

> European contacts universally acclaimed health, well being, and vigour of the Indian people they met. However, with the invasion of foreigners, came their way of life, their foods as well as their diseases. (Starblanket, 1979:3)

Nicholas Denys wrote in 1672:

> They were not subject to disease, and knew nothing of fevers. If any accident happened to them --- they did not need a physician. They had knowledge of herbs, of which they made use and straight away grew well. They were not subject to the gout, gravel, fevers, or rheumatism. The general remedy was to make themselves sweat, something which they did every month or even oftener. (Berger, 1980)

But the new diseases brought by the Europeans were diseases with which the Indian had not had experience, to which they had no immunity, and for which they had no effective medical treatment.

Smallpox, whooping cough, tuberculosis, measles, chicken pox, bubonic plague, typhus, malaria, diphtheria and influenza swept through the Indian populations. By the beginning of the twentieth century, the Indians had been reduced to a state of complete destitution and dependence. The loss of whole generations, the enfeeblement of those who remained, the fear of demographic destruction, the loss of faith in their own institutions and in their own values resulted in demoralization and a sense of powerlessness in Indian communities throughout the country (Berger, 1980).

The problems of Indian health are, in part, the outcome of centuries of oppression, of the domination of one society by another. Noel Starblanket, President of the National Indian Brotherhood, speaking at the Opening Ceremonies of

the Battleford Indian Health Centre on July 26, 1979, expressed the Indian point of view:

> To be forced to live a life that is totally out of one's own control is a source of constant stress, and leads to the weakness and demoralization of individuals and entire communities. We as Indian people have been forced into coerced dependence upon paternalistic and ever-shifting federal policies and this situation has contributed to a great extent to the manifestations of social ill health now seen among us, including alcohol and drug abuse, family breakdown, suicides, accidents, and violent deaths. There is increasing scientific evidence that the stress of dependence and uncertainty leads to physical sickness and disease as well. (Starblanket, 1979:6).

Alcohol was linked to demoralization and decay, but, advises the Report of Advisory Commission of Indian and Inuit Consultation, it should not be regarded as the cause (Berger, 1983). Execessive use of alcohol, a manifestation of disintegration of Native society, accelerated and compounded the socio-cultural process, while taking its own immense toll of life. It remains a major concern to the development of healthy communities as its use is associated with the epidemic of violence in Native communities and with the Fetal Alcohol Syndrome.

The interrelationship between health and health care and other factors such as education, child welfare, housing, employment and community infrastructure cannot be denied. Although health care, particularly preventive health care, should be an essential component of many other programs and activities, this has been difficult to achieve on reserves. Band councils and members set varying priorities to issues concerned with preserving cultural integrity, such as land claims, unemployment, housing and religious-cultural acti-

vities. Frequently there is no way to earn an adequate living on the reserve and unemployment rates are high. Housing is always at a premium. Nineteen percent of on-reserve homes have two or more families living in them. This situation affects 40% of all status Indian families (Penner, 1983). Certainly the Native peoples' living condition, since contact, has never approached that of their Euro-Canadian neighbours. Poverty, poor housing, lack of clean water, inadequate sewage and garbage disposal and poor diet are all too often charactistics of reserve life. Until improvements are made in these underlying conditions, efforts to improve health will be inadequate (Berger, 1980).

Responsibility for Indian Health Services is currently exercised by the Department of National Health and Welfare. At one time all health services were delivered through federal medical facilities established throughout the country, but gradually the federal government made arrangements with the provinces to deliver hospital services for Indians through the provincial hospitalizaton system. National Health and Welfare, through Medical Services Branch, continues to be responsible for primary preventive care and operates approximately 400 nursing stations and other health facilities (Penner, 1983). Some of these facilities also offer medical care. The transfer of responsibility between federal and provincial governments is neither comprehensive, nor consistent, and many jurisdictional questions remain regarding the gaps.

In 1979, the federal government commissioned an enquiry into Indian Health and issued a general statement of current assumptions and objectives as a foundation for

policy designed to promote and encourage Indian involvement in the provision of health services (National Commission Inquiry on Indian Health, 1979; Begin, 1980). A process of devolution was begun whereby many health services would be administered at the band level. However, this did not include a transfer of control and the real power remains with National Health and Welfare. Nonetheless, several Native peoples' groups have taken steps to assume control over health matters, essentially those of primary prevention. This has taken various administrative and jurisdictional forms. In Alberta, a province- wide Board of Indian claims, unemployment, housing and religious-cultural activities. Frequently there is no way to earn an Indian Health Care Commission; whereas the Cree Board of Health and Social Services in Ontario was created so that local and regional control of health and social services could be attained. Several tribal councils comprised of bands in regions of British Columbia, have assumed responsibility for administering health promotion and primary prevention services and employing Native or culturally-sensitive non-Native health care workers. These projects are still in the development phases and undergoing growing pains. Although there is as yet no formal evaluation their continued survival is indicative of some success.

The medicine man was a powerful person in the folk health care section, (Jenness, 1955; Gunther, 1949). He was a prophet and seer; a healer and sorcerer. He was a social and political leader as well as spiritual advisor (Amoss, 1972; Burger, 1980; Boas, 1980; Drucker, 1965; Duff, 1965; Jilek, 1978; Storm, 1972). As a man of God, he held great power, interpreted visions and dreams, proclaimed taboos, led ceremonies and prayers and healed with herbs and laying

on of hands (Cardinal, 1969). National Health and Welfare officials and others, according to Penner (1983) have slowly come to appreciate the relevance and the utility of traditional approaches, particularly with respect to mental health problems such as suicide and addictions. In areas such as these the application of traditional medicine and Native culture perhaps can be more successful than anything that could be offered in terms of contemporary psychiatric approaches to those kinds of problems (Jilek & Jilek-Aall, 1978).

Since traditional practices are particularly important in the provision of health services, Native involvement in planning and delivering services is essential. The Native peoples found that the corporate organization of Medical Services Branch foreign to their tradition of 'clan' social structure and often a cause of family conflicts (Penner, 1983). Traditional medicine, the medicine man and the healing powers of herbs and barks remain salient to the maintenance of health. Farris (1978) reminds us that pregnancy is considered a normal event. Although modern health care may be sought, religious activities, traditional medicines, and when available, the medicine man, perform intregral functions to ensure healthy outcomes. Without recognition from the non-Native health professionals traditional practices have the potential for conflicting with their recommendations. The dilemma created requires that one party's recommendations be ignored: which one rejected would depend upon the situational context.

> Ultimately the health system must encourage wellness, self-care, prevention, and family development. It must utilize traditional medicine mechanisms, and encourage self-reliance

> and dignity in the delivery of an essential community service (Starblanket, 1979: 2-3).

The relevance and utility of traditional approaches to childbearing might well be essential to a healthy outcome of pregnancy.

A holistic approach is advocated by the Native peoples and supported, at least philosophically, by Health and Welfare officials (Penner, 1983). The report of the Kwakiutl tribe to the Task Force on Indian Self-Government, expressed this approach when it defined health: "Health has a less tangible dimension, not demonstrable by death or disease statistics, yet just as real and possibly more important. It is 'whole health', involving spiritual, social and mental aspects of the life of the individual and the community. It is 'health as stength' --- as togetherness, as harmony with the universe, as self-esteem, pride in self and group, as reliance, as coping, as joy in living ---" (Penner, 1983:34). Health includes mental health; a sense of psychic well being rather than just the absence of certain disabilitating behavior symptoms. It involves self-esteem and a feeling of power (Bullough & Bullough, 1982).

The Indian Health Discussion Paper (Begin, 1980) suggests that if pregnant women are to have an optimal opportunity for a normal delivery, there must be increased awareness of their physical, nutritional, and emotional needs. "Too many women delay seeking antenatal care. Too often physicians and, in some instances, nurses fail to take into account cultural needs, living conditions, and economic problems of their patients. Inappropriate medical advice or lack of attention by a mother to her needs can result in

poor antenatal care which increases the risk of complications...." (Begin, 1980:8).

The Fetal Alcohol Syndrome

The association between Native people's health status and use of alcohol has a long history. An escalating spiral has developed among many Native groups such that demoralization, loss of pride in Indian identity and apathy have increased, leading to and being further supported by, excessive alcohol consumption. Not only is this situation detrimental to the present generation but sequalae in future generations are predictable.

Historically, alcohol has often been noted by both scientists and humanists to have an adverse effect on offspring. Passages in the Bible, early Cartheagian laws and a 1834 report to the British House of Commons admonished women of childbearing status to abstain from wine and strong drink for fear of producing a defective child. Although Aristotle described characteristics of infants born to drunken women, a paucity of scientific endeavors existed until Lemoine and colleagues (1968) and Jones and Smith (1973) identified the Fetal Alcohol Syndrome and correlated this with the teratogenic effects of alcohol.

The Fetal Alcohol Syndrome has attracted much interest because of its unique and early recognizable constellation of features which include: retarded growth and development with prenatal and postnatal growth deficiency; behavioral impairments, mental deficiency and fine motor dysfunction; characteristic patterns of malformations of the face and limbs; and cardiac defects and other anomolies. However,

it is becoming increasingly evident that maternal alcohol consumption is related to a whole spectrum of events from early fetal wastage to learning and behavior disorders manifested later in childhood: i.e. fetal alcohol effects (Rosett, 1981).

The dimension and variability of maternal alcohol consumption contributes to the spectrum of fetal alcohol effects. Although it is evident that alcoholic drinking is not necessary to produce fetal alcohol effects, the minimal alcohol consumption or drinking behavior critical to the production of the fetal alcohol effects or syndrome are unknown. Recent findings suggest that later learning snd behavior problems in children may be associated with social drinking by the mother prior to and during pregnancy (Landesman-Dwyer, 1979). On the other hand, a change in drinking behavior from heavy to moderate drinking during pregnancy has been shown to benefit fetal outcome (Rosett, Weiner, Zuckerman et al, 1980; Little, 1977). Women state that these changes are both involuntary (Hook, 1976; Little and Hook, 1979) and voluntary (Rosett, Oullete, Weiner, et al, 1978; Little, Streissguth, Barr and Herman, 1980).

Prevalence and incidence rates for fetal alcohol effects are difficult to estimate for a number of reasons. There is difficulty in accurately determining the dimensions of the complex behavior, drinking, of women prior to and during pregnancy. Although a relationship between alcoholic drinking and fetal effects has been identified in humans, the nature and threshold of a dose-response relationship has not been established. The situation is complicated also by the fact that the teratogenic agent, alcohol, consumed by the mother may interact with other

environmental factors (e.g. nutrition) but the outcome measured is the indirect effect on the fetus. It is difficult to measure and determine the action of the intervening variables in the dose-response relationships. Many of the effects of an alcohol-influenced-pregnancy are latent in the infant and may not be identified until the child is older or in school.

The available prevalence rates for infants born to alcoholic mothers range from 26-35% for the full syndrome (Jones, Smith, Ulleland and Streissguth, 1973; Majewski, Bierich, Loeser et al, 1976; Oullette, Rosett, Rosman, 1977) to 75% for partial effects (Olegard, Sobel, Aronsson et al, 1979; Majewski, Bierich, Loesser, et al, 1976). Incidence rates for full and partial fetal alcohol effects have been estimated between 2.2 to 1 per 1000 live births (Dehaene, Crepin, Samaille-Villete et al, 1977; Olegard, Sobel, Aronsson et al, 1979; Hanson, Streissguth, Smith, 1978; MacLeod, 1981). In British Columbia an incidence of approximately 1 in 1000 live births has been estimated, amounting to 35 new cases of Fetal Alcohol Syndrome per year (MacLeod, 1981). If the risk ratio were similar for Natives as for the general population, this would mean 27 new cases born yearly to the Registered Native population of British Columbia (based on a birth rate of 23/1000, population of 34,000, and total births of 782). The British Columbia Health Surveillance Registry (1981) has reported a prevalence of 93 Fetal Alcohol Syndrome offspring at year-end 1980 for the 0-19 year old population (n=819,900). Of 76 cases referred for fetal alcohol syndrome diagnosis and treatment, 69 were born to North American Indian Women (Smith, Sandor, Macleod et al, 1981): a finding similar to Asante (1981). However, the

populations from which these cases were drawn were primarily comprised of Native peoples.

It may be that Canadian Indians have been over-represented in terms of their proportion to the total number of Fetal Alcohol Syndrome cases reported, as has been suggested in the American Indian situation. Leland (1978) noted that some people have inappropriately interpreted the high proportion of Indian women in the reports as evidence that they suffer higher problems drinking rates than women in the general population distribution. The literature contains little support for such a conclusion since most reports on Indian drinking include no data at all on females.

Nonetheless, the problem is of significant proportion to be a major health problem of the childbearing period. Alertness to the Fetal Alcohol Syndrome could result in early detection of drinking problems among Native mothers, at a time when concern for their new babies might create a particularly propitious oppotunity for successful intervention. The strong affection shown for their children suggests that knowledge about possible damage to them might become a powerful factor in discouraging alcohol abuse among women (Leland, 1978).

Summary

To change their health status, the Native peoples are determined to regain faith in themselves and forge their own distinctive and contemporary identity, remaining a distinct people in the midst of Canadian society. They are calling for self-determination in all aspects of their

lives. Their perspectives that basic health care should be encouraged, not delivered, and that health and medical knowledge should be shared, approaches the tenets of primary health care espoused at the Alma-Ata Conference (Declaration of Alma-Ata, 1978). The Community Health Representatives (CHRs) trained by Medical Services Branch and employed by band councils assist in providing primary health care in Indian communities. At least in policy, the government of Canada is supportive of this approach. The Indian Health Policy's goals is to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves. The means to this end are defined as being based on three pillars: orientation to community development (socio-economic, cultural and spiritual), traditional relationships of the Indian people to the federal government (open communication and participatory involvement) and the objectives of the Canadian health system (federal, provincial or municipal governments, Indian bands or the private sector). The negotiating between Bands and Health and Welfare Canada goes on today.

Coast Salish Native Peoples

The Context

The North Pacific Coast of America is inhabited by a great many Indian tribes distinct in physical characteristics and distinct in language, but sharing much in other cultural respects. (Map 1: Map of Northwest Coast Tribes) The extent of this cultural uniformity makes these Indian tribes one of the best defined cultural groups of the continent (Boas, 1980). Sapir (1980) groups the Coast

Salish with the Nootka and southern Kwakiutl as being most similar, especially with respect to their social organization. They have in recent times acquired much of the Native culture of the North Vancouver Island tribes, yet have strong historic connections and language similarities with the Salish Indians of the Interior (Ashwell, 1978). There is evidence to suggest that the Coast Salish originally migrated to the Northwest Coast in waves of successive groups, coming from the Interior Plateau on the upper reaches of the Fraser and Thompson Rivers (Ashwell, 1978; Hill-Tout, 1978).

Location

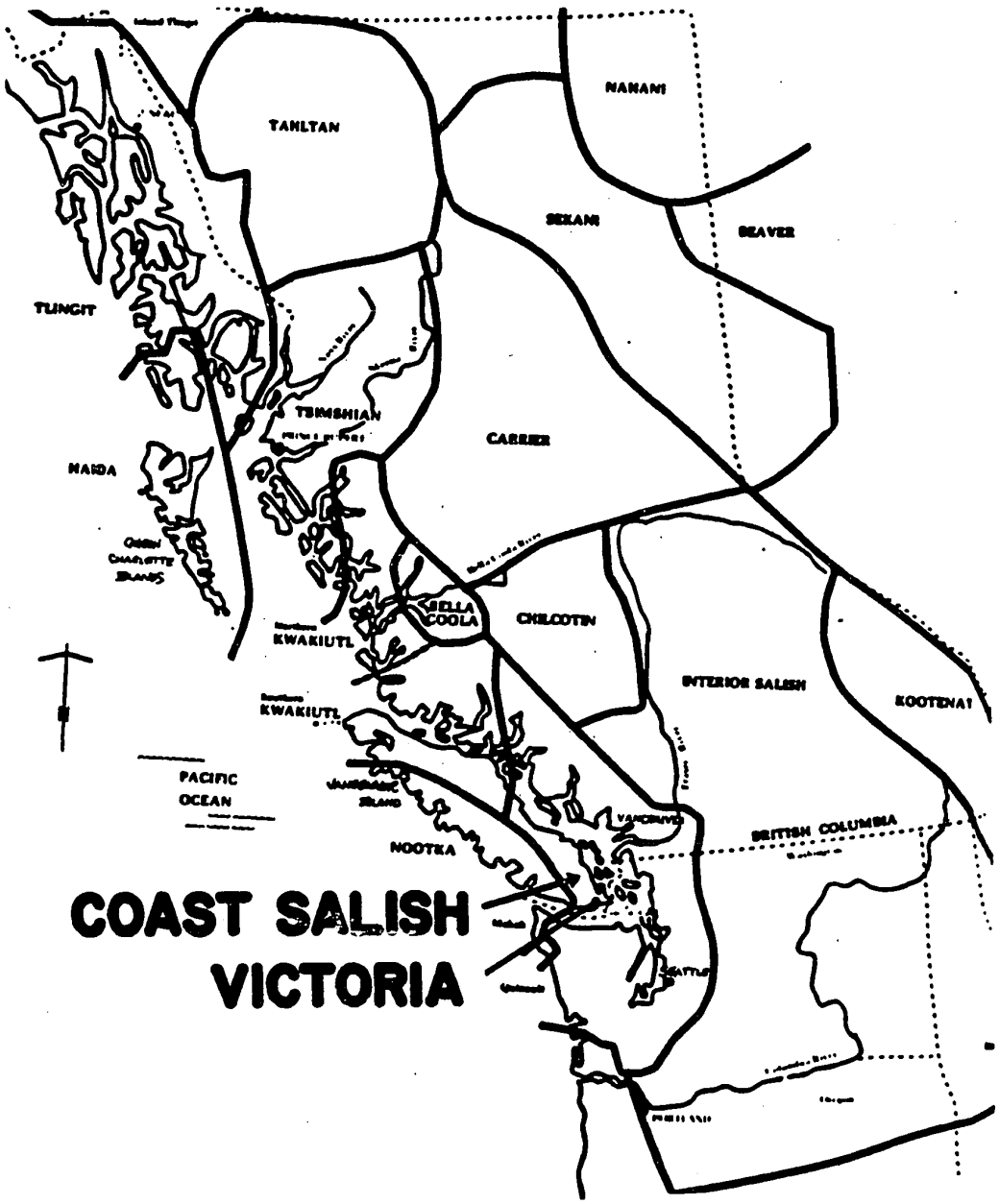
However, the Coast Salish people are also unique among the Indians of the Pacific Northwest. They are located primarily on the southeast portion of Vancouver Island and the south-west coast of the mainland of British Columbia, Canada and the state of Washington, United States of America, with their eastern boundry reaching the Fraser River (Map 1: Map of Northwest Coast Tribes). Because the Coast Salish occupied such a diversified environment, they acquired a unique variety of cultural traits and social organization based on a patrilineal hunting, fishing and gathering band.

Resources for Subsistence

Upon migration from the harsher interior climates, the Coast Salish people found a wealth of readily available natural resources along the coast - fish, game, berries,

MAP 1

Map of Northwest Tribes



bulbs and roots. Men hunted and fished, while women gathered shellfish, fruits and berries, seaweed, and roots, and processed the food for winter storage. Children accompanied their parents and elders and assisted in the work: an essential part of their training.

Salmon was by far the most important food and the coming of the first spring salmon the most important event of the year. The salmon needed to be treated with proper respect; each band had its own ceremony and directions for cleaning and cooking the fish (Ashwell, 1978). Other foods included halibut, shellfish, small sea mammals (seals and porpoises), waterfowl, and occasionally deer, elk and small land game. Even though there was abundance of food in the various seasons, McKechnie's (1972) account of Northwest Coast Natives suggests a somewhat less than ideal state of nutrition. He claims that they tended to live from day to day. "This reliance on fish for food, plus their relative improvidence, led to nutritional imbalances and even to starvation at times" (McKechnie, 1972:19). Although this may be a rather broad generalization, there was no doubt that some individuals did not enjoy the degree of health described previously. Yet today many of the Coast Salish peoples continue to prefer the traditional "Indian Food" and means of preserving it, albeit their diet is supplemented with non-Native commodities.

The giant cedar tree forests provided suitable material for large community-style buildings and canoes, as well as carved masks for Shamanistic rituals and Ceremonial Dances. Women stripped the bark, careful not to injure or kill the tree, for making baskets and weaving skirts. The importance of the western red cedar to the Indian tribes of

the Northwest Coast is still evident today, as they reverently carve masks and totem poles reflecting their cultural tradition.

Housing

Historically, the huge wooden plank houses which lined the shores of the Northwest Coast harbors divided the village community into a number of large house-groups. Each house possessed its own long shed-roofed dwelling, set of ancestral names or titles and stock of legends, songs and medicinal remedies (Jenness, 1973). The multi-family dwellings were usually built in a shed type style with the flat roofs gently pitched because of the great width of the structures. The Coast Salish found these roofs very useful for drying fish, as well as handy platforms for viewing the Potlatches and other ceremonial gatherings and festivities (Ashwell, 1978). During the summer months, the Coast Salish all but abandoned their winter long houses and journeyed away on prolonged camping trip for the purpose of obtaining food supplies.

Lifestyles

Activity in a Coast Salish village varied with the season. When the salmon were running and berries were plentiful, the whole willage was busy. Whereas during the winter months, periods of extended leisure from substance activities allowed time for games, dances and other ceremonies. However, with government restrictions of the 1860's, the Coast Salish were forced to give up their somewhat nomadic lifestyle and live within confined geographical boundries.

Ceremonies - Rituals

Religion

Similar to other Northwest Coast tribes, among the Coast Salish almost every action in life centered around spirit powers (Ashwell, 1978). The most important aspect of their religion was the guardian spirit guest by which the individual acquired a supernatural protection for life. Complete protection was impossible, however, for there was always a danger of sorcery should one antagonize a person whose guardian spirit was more powerful.

In traditional Salish society, the quest for spirit power had to be completed in adolescence or young adulthood. The spirit power acquired helped give identity and ward off the frustration and depression which accompanies role confusion at that critical stage of personality development (Jilek, 1977).

> Today, the individual rebirth of the initiate is placed in the context of a collective Indian renaissance. In the spirit dance initiation the Native person not only acquires individual spirit power by his rebirth as a true Indian, he overcomes sickness, and faulty behavior seen as contracted by exposure to an alien culture (Jilek, 1977:51).

There was belief in a "Creator of the World" but his powers did not appear to have been absolute, as many spirit forms, guardian spirits and supernatural beings lived in the world of the Coast Salish. All objects, whether animate or inanimate, contained spirits which could influence the Indian's life. Therefore, one had to constantly strive to positively influence these spirits, preserving a oneness

with nature and respecting all animals and their dwelling places.

Although not as numerous or well organized as other Northwestern tribes, the Coast Salish had secret societies for religious purposes. Initiation played an important part and novices were required to be of pure mind and unimpeachable behavior. When the probationer was granted entry into the society, he traditionally disappeared into the woods where he fasted, bathed frequently in cold water and scrubbed himself with rough cedar boughs. The combination of extreme physiological deprivation and psychological preparation eventually brought about a successful outcome to the vision quest. Once he found his guardian spirit, he performed his dance and sang his song to reveal his membership to the people (Ashwell, 1978).

Girls underwent a similar, but somewhat less rigorous quest (Barnett, 1975). The onset of a Coast Salish girl's puberty was the first major crisis through which she passed. At this time she was secluded and could not see other people, nor be seen by them; the exception was an elder female relative who attended and instructed her for four days (Drucker, 1965; Jenness, 1973). The intent was to seek supernatural help to make herself industrious and attractive for marriage. This was a critical stage of the lifecycle when a woman was both ritually unclean and possessed with spiritual power. Food restrictions were severe, and taboos existed with respect to the salmon and hunting and fishing. To avoid contamination of one's unclean state, drinking tubes and scratching sticks were used. At the termination of the seclusion, a purification ritual took place followed by a public debut or Potlatch:

an announcement of her status as a mature woman (Drucker, 1965).

With this new status, she was deemed ready for marriage. Her subsequent menstrual periods were occasions for attenuated repetitions of the puberty seclusions, with similar dietary and relationship restrictions. Her behavior at these times was vital to her band or group because her presence could influence hunters and fishermen and endanger the life of a Shaman and those in close contact with spirit powers (Dricker, 1965).

Art/Games

Basketry, weaving, knitting and carving were trademarks of Coast Salish art and crafts and contributed significantly to their economy in recent years. Games and sports included bone games, soccer and canoe racing ("Pulling"). A team approach rather than individual orientation was the norm. Pennier (1972) recounts about his lacrosse days:

> ... I sure loved that fast game. A lot of us young fellows formed a club....There were a lot of teams around the valley by then, a lot of them Indian (Pennier, 1972:44).

Games were not just a simple set of rules, but meaningful functions, serving as a form of social expression (Maranda, 1972). As such they were forums for supernatural powers. The games were useful devices to measure the differential degrees or strengths of power among the players. "Slahal", the bone game, also known as the hand game, was a popular sport of these reasons (Maranda, 1972). Leaders were usually great gamblers whose participation ensured success for the team because they had the "hand game gambling

powers". Supporters were involved with singing, drumming and betting - one way to maintain intergroup ties and reafffirm Indian identity.

A period of low years in the cultural history of the Northwest Indians came with the ban on Potlatch, Shamanism and authorities of chiefs and nobles and continued until after the 1950's (Ashwell, 1978). In recent years, however, like other Indian tribes, the Coast Salish have found new pride in their cultural heritage. Some of the elders, knowledgable about the traditional beliefs and customs, have exerted a powerful influence among their people. A renaissance in art, games, Potlatches and other traditional customs has spread among many of the Coast Salish bands.

Morals-values

The Coast Salish, along with other Indian tribes, had no written language and therefore stories of tribal origin, history, achievements and newly learned facts had to be passed on verbally from one generation to the next through myths and legends. Storytelling was an essential part of the cultural heritage of the Coast Salish with children gathered around lodge fires, ceremonial songs sung in long houses and spirit dances performed when people gathered for the winter ceremonials (Ashwell, 1978). The Indian's method of recording a significant event was to weave a legend about it. Legends were the link to the past and the teachings for the present. Because of their frequent allegorical form, the listener (recipient) had to work at understanding the meaning as well as remembering the form. This was a means of reinforcing the learning process.

A possession of private or guarded knowledge was theoretically necessary to upper-class status (Suttles, 1980). Known as "advice", it consisted of geneologies and family traditions revealing family greatness, gossip about other families demonstrating how inferior they were, instructions in practical matters (e.g. how to quest for the right kind of guardian spirit) and moral training (Suttles, 1980).

The well-being of the community relied heavily on the appropriate behavior of its members, especially at crucial stages in the life cycle. The well-being of the member was in turn influenced by her environment.

> If what one values may be partially determined by what one talks about, then experiences of childhood and youth ...(are) very important and (have) an effect on how (one) experiences pregnancy. Kin relationships, including the extended family and tribe, exert social control and was perceived ... as contributing strongly to self-image and identity (Horn, 1975: 253-4).

Kinship System

Social Organization

The primary social group was the local group: a group of people sharing rights to the utilization of economically important places of subsistence resources and occupying a common village. Every village was a unit by itself, linked by economic and cultural ties and by intermarriage with neighboring villages (Jenness, 1973). Drucker (1980) states that "... everywhere this social division was no more and no less then an extended family (slaves of course excluded) and was so considered by its members" (139). The individual of the highest rank in the social unit was at

least distantly related to the lowliest. Ties of kinship, as well as common residence and common economic resources welded the group together. The community was linked through ties of marriage and kinship with other communities and these with still others to form a social network with no very clear boundries. Each village or band maintained a political distinctiveness though, with members of a single band usually showing more cohesion and cooperation in facing outside issues than did members of different bands (Robinson, 1963).

Rank

Similar to the Nootka and Southern Kwakiutl but to a lesser extent, the Coast Salish tribes were characterized by the concept of rank (Sapir, 1980). Emphasis was placed on rank with three classes of society recognized: the nobility, the commoners and the slaves. Intermarriages between nobles and commoners or slaves and between commoners and slaves was rare and in theory impossible. Coast Salish society consisted of a large upper-class of good people, a smaller lower class of worthless people and a still smaller class of slaves. Within the upper class there were status differences due mainly to differences in wealth (Suttles, 1980). High rank was primarily determined by heredity and by wealth (Drucker, 1980).

The extended family or band heads were the individuals referred to commonly as "chiefs" (Drucker, 1980). Close relatives were ranked according to their nearness to him. The rank of chief or noble was connected in most cases with a certain degree of personal power, with real communal authority vested in only the highest chief(s) of the

village (Sapir, 1980). Individuals of high rank were also entitled to exercise a variety of privileges: practical rights of economic value (e.g. right to a particular fishing ground) and ceremonial and other material rights (e.g. use of certain carvings or paintings, names and crests).

People who were not high class were referred to by terms which are translated as "poor people", "nothing people" or "low-class people" (Suttles, 1980). They lacked the "advice" and private, privileged knowledge of the high class and apparently had little cultural tradition to pass down through the generations. Suttles (1980) found in his extensive work with many Salish bands that this group of people was small in number compared to the high class and that few Native people were willing to identify, or be identified as, low-class. The high class members did not want to admit that they knew or associated with someone of low-class, and those of low-class did not want to acknowledge their social status.

According to Coast Salish theory, it was possible for social mobility with the accumulation of wealth: a function of spirit power. In theory, spirits could be obtained by anyone who had the courage and endurance to fast and bathe and seek spirit vision (Suttles, 1980; Amoss, 1972). All persons likely to accumulate wealth were successful in doing so, it was thought, because they had guardian spirits. Private or guarded knowledge was also a necessary possession for upper class status (Suttles, 1980). Thus, hereditary wealth to support a high class rank must include not only material possession, but spirit power and private knowledge as well.

Benedict (1934) found, however, that heredity privileges were at minimum. Every man had, according to his ability, practically the same opportunity as any other man. His importance depended on his skill in hunting, or his luck in gambling or his success in manipulating his supernatural claims as a Shaman. This was more the result of person-environment transactions and learning than innate or hereditary transmission. Nonetheless, privileges existed and were in a way bound to the land as they originated with a particular tribe in a specific geographic location. This connection is one of the underlying reasons why land claims and relocation issues delve deep into the hearts and souls of Native peoples, taking priority over many other issues.

Kinship

Kinship was reckoned bilaterally but residence was patri-local, so membership in a lineage was usually through the male line (Suttles, 1980; Jennness, 1980). Marital unions, arranged in accordance with the system of rank, were a social phenomenon, based on the interests of the two groups of kin and not on personal preference (Drucker, 1965). They involved demonstrations of wealth in a Potlatch and determined one's status. Primogeneture was not always the practiced principle of inheritance. Rights, such as great names, often went to the child judged to be potentially the most successful and "advice" went to the child with the best memory (Suttles, 1980).

Kinship terms used suggest the importance of particular relationships. Suttles (1980) suggests that this structure shows the "direction of the marriage" - i.e. the direction of movement of women as wives. The Coast Salish

terms for blood kin are bilateral with lineal and collateral kin distinguished in parent's and children's generations, consistent with the respect expected for both older men and women. Sibling terms, used also for cousins, distinguished between older and younger children, indicating the importance of age and extended family (Suttles, 1980). The affinal terms lump persons of different generations. The most socially important affinal kinship term is that given to the child's spouse's parent: people linked by marriage to their children. These are the people who exchange wealth at weddings and throughout life as long as the marriage lasts (Suttles, 1980).

Role of Women

Cruickshank (1969) suggests that women's role is potentially the most important in determining the direction of change within Native communities because, despite the radical alterations in the Native way of life, the role of the mother links both traditional and contemporary, the past and the future: they maintain ethnic identity for the family. The woman is supposed to keep the family stable to withstand breakdown, but flexible to adapt to change.

Dr. Marlene Castellano, an outstanding example of Native womanhood, said in her essay:

> Native women in the past held mainly to themselves, for they did not seek notoriety beyond the bounds of their community. Their accomplishments were not of the sort to bring them fame. They seemed content to form the backdrop against which the man played the starring roles. Yet they commanded a respect and wielded an influence which might be the envy of the modern advocate of women's rights (Castellano, 1975:15).

Females learned their roles more informally than males. They associated with their mother and other women and were taught to take domestic initiatives in ways complementary to males. Because of the absence of highly imposed rules about the conduct of the ideal women, they had greater latitude in defined areas in which they wished to operate; whereas males were trained with specific goals in mind (Landes, 1938). Cruickshank (1969) speculated that this has enhanced Native women's ability to adapt to social change. Women may suffer less acculturation stress because their traditional role in rearing children and carrying out domestic tasks is changed less than the male traditional roles of hunter, warrior, and Shaman, and because in their education women were taught skills useful to reservation, as well as to the larger society life (Lurie, 1972). Thus the women were more flexible. However, being a mother and rearing a family were the ultimate achievements for Native women.

Since the early 1960's, Native women have been stepping out of anonymity of their reservation life to take a more active role in society in such capacities as nurses, social workers and community health representatives. Jilek-Aall (1983), with the assistance of Native women such as these, surveyed a sample of 48 Coast Salish women. The aim of the research was to understand the goals and sources of strength of Native women. Over half of the Native women in the study stated that getting married and having children were the most important events in their adult life and about one third named social achievement, such as going back to school, as highlights in their lives. Education, they said, made them self-confident and independent and helped them overcome the depressing realities of reserva-

tion life, but their goals were not to benefit themselves so much as they were to "help others". When asked what had contributed most to their coping ability and personal resourcefulness, positive Indian identification was the most important source of strength (Jilek-Aall, 1983). Over one quarter of the young women and two thirds of the older women exphasized that the hardships they had experienced and the challenge of overcoming the social adversities of being Indian made them stronger.

These findings tend to contradict the historical picture of women's roles: subordinate and inferior in status from the time of birth, faced with less hardship and risk than males, and doomed to a life of drudgery. Male traders, barred from female company except when husbands were present, interpreted the position of women in terms of their own culture, while missionaries focussed on pathological aspects of culture, as they were there to change beliefs, and anthropologists were for the most part males, unable to obtain information of women, but believing that women were subordinate to the males (Cruickshank, 1969).

Knowledge and Beliefs

Health

The Coast Salish were an outdoors people: eating a diet from the natural resource of the land, bathing early in the morning in the natural waters and attending to personal hygiene with such aids as thimble-berry bark soap and sea lettuce lotion (Ashwell, 1978). Ritualistic customs often

encouraged a healthy way of life. Bathing was considered a purification rite as cleanliness was a necessary prelude to success and allowed the spirits to come and warn of approaching danger (McKechnie, 1972).

The Coast Salish believed that illness originated as an evil spirit which had penetrated the body and induced pain and suffering - another reason why their lives had to be lived in harmony with the spirits. No essential distinction was made between physical and mental illness. Other less common illnesses were spirit sickness (a seasonally limited ritualized state identifiable on the basis of learned stereotyped symptoms required for the "rite de passage" of spirit dance initiation) and soul loss (manifested in lethargy and apathy) (McKechnie, 1972; Jilek and Jilek-Aall, 1978). Spirit sickness has been defined by Jilek and Jilek-Aall (1978) as anomic depression - a chronic dysphoric state characterized by feelings of existential frustration, discouragement, defeat and lowered self-esteem. It derives from experiences of anomie, relative deprivation and cultural identity confusion (Jilek, 1977).

Medicine Men

The Shaman was a very important man in his community. He was the Medicine Man, but also played a leading part in all ceremonial functions and was sought after for his help and advice in times of trouble and distress (Ashwell, 1978). Medicine and religion were closely associated, if not one and the same. The Shamen often affected remarkable cures and among the Native peoples there persisted a firm belief in his powers and in his ability to cure people of sickness and suffering (McKechnie, 1972).

Among the Coast Salish there were two classes of Shamen - those who held supreme powers in the arts of clairvoyance, the curing of the sick and the controlling of the ghosts and shadows of men, and those of lesser powers who concerned themselves with minor illnesses and warded off adverse influences. The latter were usually women who applied themselves mostly to the practice of midwifery (Ashwell, 1978). With the passing of the Indian Act and outlawing of the Potlatch, Shamanistic practices, including midwifery, became illegal. Thus, even this oral tradition and knowledge has been significantly depleted with non-use.

Medical knowledge of the Shaman, midwife and family was passed from generation to generation with the telling of medical legends of the spirits of plants, animals or the dead: spirits that were believed capable of causing or curing specific illnesses. The art of the Shaman was often handed down from maternal uncle to nephew. Because indoctrination took years with many things to be learned, including medicine-making, the candidate was usually chosen at an early age. One of the major criteria for the choice was the psychological sensitivity of the individual.

Healing

> The health care system of the Coastal Indians, remarkable as it was, was handicapped by the absence of a written language. All knowledge, medical and otherwise was handed down by word of mouth from one generation to the next (McKecknie, 1972:14).

This verbal method of passing on information lacked the cummulative power of the written word, a requirement for progressively constructive diagnostic and therapeutic refinements of the Shamam.

Since the demise of much of the Shamanism practices, contemporary spirit dance and winter ceremonial initiations are understood to be alternative curing processes. They are based on the therapeutic myth of death and rebirth. The revised spirit ceremonial provides the initiated dancers, and to some extent their relatives who assist and witness, with an annual winter treatment program. Physical fitness and sobriety are required, respect is gained, and support, protection, acceptance and stimulation are found in group solidarity (Jilek, 1977).

Another Indian healing ceremony found in the Shaker Church relies on family members, relatives, neighbors and friends to take part in the procedure with "helpers" and drummers assisting (Amoss, 1972). The sick person experiences the support of all these people and the belief in super-naturally sanctioned Indian healing rites (Jilek-Aall, 1976). Shaker healing procedures may last for hours and continue far into the night with improvement expected by the fourth ceremony. At times the healer or Shaman performs ritualistic songs and dances and sprinkles water over the patient; at other times he may attempt to draw out the evil spirit by sucking on the afflicted part.

Childbearing

It is suggested that among all Northwest Coast peoples crucial stages in the life cycle of the individual were times to protect the individual and group by special ritual (Drucker, 1965). Childbearing was considered to be a stage in one's life that required special treatment. The concept underlying such special treatment, or rites, was that the mother during this time of change was in a peculiar

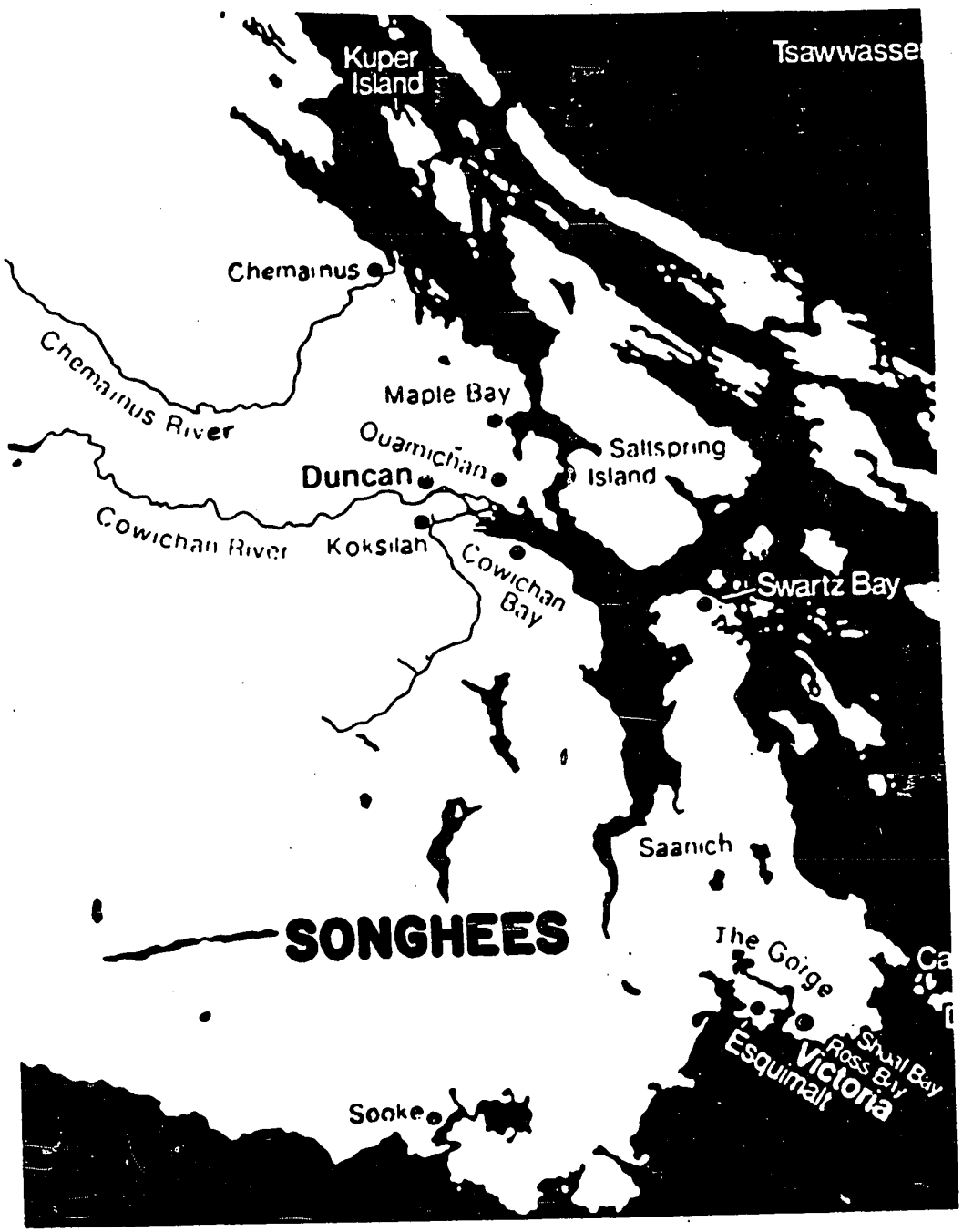
condition of ritual uncleanliness, offensive to supernatural beings, but was simultaneously imbued with magical powers capable of causing good or harm. When a member of society undergoes a change in either social status or state of being, she and all those around her are exceptionally vulnerable to harmful yet mysterious forces (Robinson, 1963). Fish and game were considered to be most susceptible. Thus they were tabu to the pregnant women, whose diet was limited to old dried fish and activity requiring seclusion from the sight of fishermen and hunters and staying away from salmon streams (Drucker, 1965; Benedict, 1934).

Very little is known about the childbearing beliefs, values and practices of the Coast Salish. The few anthropological writings that even mention women or childbearing give an emic and etic male-based perspective. One notable exception is the publication of the students of The Native Infant Education and Care Program, Duncan, British Columbia (Students, 1982). They documented some teachings of the Elders of the Cowichan Band, a Coast Salish tribe. (See Map 2: Coast Salish: South Vancouver Island). Two other studies have been done with childbearing women of the Northwest Coast by non-Native female researchers (Horn, 1975; Bushnell, 1981). Bushnell (1981) categorized 25 expressed beliefs about pregnancy and childbirth while Horn (1975) studied the perceptions and cognitions of childbearing women regarding pregnancy and child care. Although pregnancy is traditionally considered a normal, natural condition, it is perceived by Native women as having regular and irregular components and having negative qualities at times (Horn, 1975; Bushnell, 1981).

For Some Northwest Coast Native women, it is believed that a mother begins to give care to her baby during pregnancy (Bushnell, 1981). Therefore, it is important to observe customs that keep evil spirits away and encourage the presence of good spirits that might protect and help the woman during the childbearing period (Drucker, 1965). The underlying beliefs of these customs directed dietary, emotional and activity customs in lifestyles (Barnett, 1939). Some of these beliefs were: if the woman looked at the bullhead, the child would be as ugly as one - "like begets like" (McKechnie, 1972); if the mother saw something ugly or unpleasant she should spit, if she saw something pleasant she should swallow (Students, 1982). When the mother swallows or views objects, it is believed she supplies her baby's senses with the same external experiences. Examples of lifestyle customs and explanations included: the pregnant mother should not touch animalsl because she supplies her baby with external experiences through her senses and the baby will develop the same physical animal characteristics (Students, 1982); restrictions of a variety of foods including crab, ling cod, abalone, octupus and berries were required because of the effect they were believed to have on the child or labor and birth (Students, 1982; McKechnie, 1972); or hesitating in a doorway or with an action would cause the childbearing woman to experience false labor near the time of birth because the baby would be hesitant about crossing over the threshold of being born (Students, 1982). Feeling states such as anger, sadness, and dissatisfaction were believed to affect the baby such that it would be born with the same disposition (Students,1982; Horn, 1975). Cultural norms also stressed health practices of walking, carrying out

MAP 2

COAST SALISH - SOUTH VANCOUVER ISLAND



usual activities and eating a nutritious diet (Horn, 1975; Bushnell, 1981).

There have also been reports of traditional medicines used in the childbearing period. In general these have to do with the birth process rather than pregnancy, and can be classified in four categories of remedies: to speed childbirth, to speed delivery of the placenta, to stop post partum hemorrhage and to relieve pain of childbirth (Jenness, 1973; Weiner, 1972). Special knowledge of the midwife or family was required in the gathering and preparation of these remedies made from berries, roots, bulbs and herbs.

While giving birth the Coast Salish woman was usually attended to by a midwife. Besides assisting with the physical process, she could also provide magical aids for childbirth such as rattle shaking, incantations, and appeal to supernatural powers, (Barnett, 1975). If a complication occurred, a medicine man, Shaman, would be required (Jenness, 1973).

After birth, the father as well as the mother, was in the dangerous state requiring seclusion and dietary restriction (Drucker, 1965; Bushnell, 1981). Typically,the seclusion of the parents was terminated by a purificatory procedure involving ritual bathing (Barnett, 1939; Drucker, 1973). These private rites were directed by a paid ritualist or a family elder. Cleansing rituals were performed to wash all those involved and fortify them with purity. Rituals were considered precautionary or preventive, rather than curative, but nonetheless essential (Robinson, 1963). Most cleansing ceremonies were in the form of songs and dances

or pantomines teaching new or altered roles during the life crises.

The newborn infant was also given special treatment. In its weak condition it had to be protected from malian influences. Tiny babies had their limbs constantly rubbed to keep them straight; noses were pinched to make them high and thin; and ears were encouraged to lay flat and close to the head (Ashwell, 1978). A flattened forehead, with the sloping upward to the crown, was considered a mark of beauty. A pad, usually of cedarbark, was attached to the baby's cradle and bound against his forehead. The importance of this flattened shape is reflected in the other name given to Salish peoples -"Flatheads" (Jenness, 1973). In addition, magical ways were used to ensure the infants health, well-being and good fortune later in life (Drucker, 1965). The detached umbilical cord, placenta and cradle board required special treatment and care (Jenness, 1973; Students,1982).

Bushnell (1981) found that there was agreement among her five subjects, 18-85 years of age, that knowledge specific to pregnancy and childbirth should be told to all women, but who should do it and how it should be done was unclear. Informants in Horn's study (1975) sought help from their mothers for information, material assistance and psychological support throughout their pregnancy. Grandmothers and sisters were perceived to be others able to offer this kind of help.

Bushnell (1981) concludes that the traditional pathway of learning from older female relatives is no longer viable for many because of a breakdown of traditional culture and

the variation of acculturation among the members of the group. However, this generalization might be seriously questioned as a vital role for elders is still tenable. The informants in Horn's study (1975) identified the following characteristics as being reinforcing in a helping relationship: that others provided information for them that they needed, that they perceived that others were concerned about them and respected them and that others anticipated their needs, including the need to know certain facts. Although this social support was identified as being helpful, it does not necessarily require only Native teachers. Bushnell (1981) found that the young Native women, under normal conditions, were becoming more acculturated into the white belief system and less dependent on their families. However, the state of childbearing may alter this independence or require the availability of Native sources of social support. Horn's analysis (1975) suggested that members of one's family of orientation were expected to provide information and to offer psychological and material support during the regular process of pregnancy and the extended family members were expected to assume responsibility when they could not be met by the family of orientation.

Entrance into the health care system was viewed as being appropriate only when illness was present: that is there was an irregular component to the process of pregnancy. Horn (1975) and Bushnell (1981) view the impact of acculturation similarly.

> Acculturation had made informants aware that the prenatal care system had goals that coincided with their goals for health during pregnancy, but participation in the system conflicted with their

> belief of no active participation (Horn, 1975:233).

Dissonance between traditional and contemporary beliefs and customs resulted in inactivity in health seeking behaviors and lack of adherence to practices that were not consistent with traditional values.

ALCOHOL USE

Discrepencies between traditional and contemporary use of alcohol may also exist. The Coast Salish patterns of drinking, associated with contemporary Indian life, are paradoxical: asserting and validating "Indianness" as separate from "Whiteness", but violating some basic traditional Indian values. It is possible that getting purposefully drunk or exhibiting drunkenness confirms the stereotype of "drunken Indian" (Lurie, 1979; Lemert, 1985), and may be an Indian thing to do when all else fails to maintain the Indian-white boundary. Drinking may be encouraged to have fun, to gain spiritual power, to be like the white man, to spite the white man and to escape from reality (Jilek-Aall, 1974; Wilson, 1983). Group drinking in one's home was the norm, with the expectation that each member would drink her/his own share, exhausting the supply. To do less would offend the host, most likely to be a relative. The similarities between this behavior and that of feasting and generosity at Potlatches is remarkable.

The majority of the alcohol studies among the Coast Salish peoples suffer the same limitations as those of childbearing: a male focus. Subjects, informants and researchers have been almost exclusively non-Native males.

Leland (1976) concludes after an extensive review of the literature that the common symptoms of alcohol use identified refer almost exclusively to males. Similar studies among Native women have not been done, nor is anything known about their drinking practices during the childearing period.

The use of alcohol by the Indians has been part of culture of the Coast Salish peoples since contact with the white man, although their pattern and reasons for drinking had a unique development. Lemert's study (1958) of three Coast Salish peoples tribes found the use of alcohol, which developed within the Potlatch tradition at the time of the early white contact, now survives as the drinking party. These parties, pervasive to the social and cultural life of the Native peoples, are generally comprised of family members; elders would tell stories and sing songs and married men and women would socialize (Robinson, 1963; Lewis , 1970). The drinking party, about the only informal social group beyond the extended family, provided a sense of solidarity. It was a means of attaining continuity with some traditional culture, but also an explanation for deviating from traditional Indian values (Lemert, 1958; Lewis, 1970; Brod, 1975). Drinking has been a part of the Native's socio-cultural activity; influencing Native ethnic identity, family cohesiveness, and the individual's self-concept.

Songhees Peoples

The Songhees People belong to the Coast Salish tribe, sharing many of the characteristics just described. Their

history is one of survival of numerous reserve relocations, disease epidemics and attempts of enforced assimilation.

Study Population

The childbearing and non-childbearing women of this ethnographic study belonged to the Songhees Band. Several of the Songhees women had transferred their membership to the Songhees Band upon marriage, as patrilocal residence is the norm and results in the woman forfeiting the right to own land in the band of her birth. Every band member is registered on a band list and a record kept of birth, marital status, death and transfer in band membership. A cash settlement is made between bands to compensate for loss of rights to land when membership changes. However, today the monies transferred are relatively small, unless a band is particularly wealthy.

The Songhees people are bound together by a diffuse web of bilateral kinship ties (Duff, 1965). They share a similar cultural heritage with other members of the Straits Salish people, an ethnic division of the Coast Salish. Although the languages of the Straits Salish are of a similar stock, each has a distinct dialect. Other members of the Straits Salish are the four Saanich bands, the Klallam, Sooke and Semiahmoo bands (Duff, 1965). (Map 3: Straits Salish Ethnic Groups).

The Songees population, like other coast tribes had been reduced considerably by contact with the Europeans. Diseases, firearms and alcohol took a substantial toll, but the smallpox epidemic which started in Victoria in 1862 had to be the most terrible single calamity to befall the

Indians of British Columbia (Duff, 1965). Unique circumstances caused it to spread faster and farther than any previous outbreak could possibly have done and within two years it had reached practically all parts of the province and killed about one third of the Native people. Today the Songhees band has only 196 members, 112 or 57% being female. It is a young population compared to the non-Native, and has both a higher birth rate and natural increase rate.

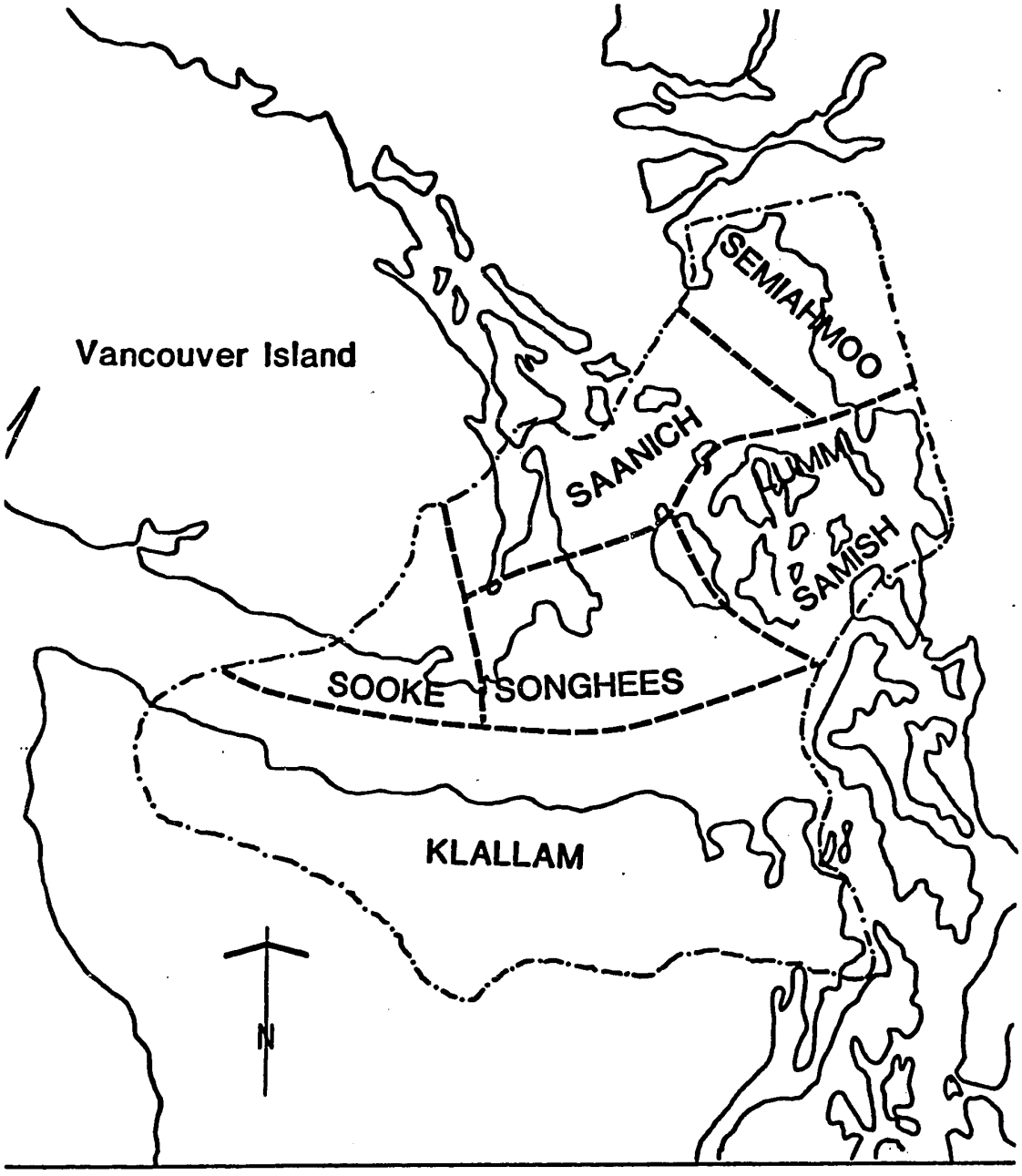
Previous Research

Four well-known anthropologists have collected ethnographic data on the Songhees Indians. Franz Boas presented his summary of data on the "Lkungen," or Songhees, in 1890 as part of his "Sixth Report of the Committee Appointed to Investigate the Physical Characters, Languages and Industrial and Social Condition of the North-Western Canada." His report was an overview of Songhees culture as part of the Coast Salish stock (Boas,1980). It focusses on major cultural aspects such as customs, beliefs and organization, but it did not answer many questions regarding Songhees daily life. Boas did not deal with the system of decision making and leadership and he did not name his informants in the report.

Charles Hill-Tout did field work amongst the Songhees in 1907, approximately twelve years after Boas. Hill-Tout summarized his field data in the Report on the Ethnology of the Southeastern Tribes of Vancouver Island British Columbia." (Hill-Tout, 1978). His report differed from Boas' work on minor points and his summary was, in the main, a description of the Songhees language. Hill-Tout's

Map 3

STRAITS SALISH ETHNIC GROUPS



Straits Salish Ethnic Groups

Adapted from Wilson Duff, "The Fort Victoria Treaties," BC Studies 3(1969),10.

report, like Boas' did not describe the Songhees daily life.

The most extensive study of the Songhees is Wane Suttles', "The Economic life of the Coast Salish of Haro and Rosario Straits", written in 1951. Suttles described the Songhees as part of the "Straits Salish" cultural unit. He explained that certain cultural traits were common to the Straits Salish as a whole due to their particular geographic location and its resources. Suttles detailed the subsistence activities of the Songhees as one group of the Straits Salish and he elaborated on the religious and social customs of these people. His informants agreed with most of the information given to Hill-Tout and Boas. Suttles incorporated field work pertaining to the Songhees neighbours from Erna Gunther's "Klallam Ethnography" and Diamond Jenness' manuscript, "The Saanich Indians of Vancouver Island". Suttles enhanced his ethnographic data with information contained in United States Government documents.

Writing on the Songhees in "The Fort Victoria Treaties", Wilson Duff drew information from settlers' reminiscences, travellers' accounts, newspaper articles, government documents, and data from Songhees informants (Duff,1969). In this article, Duff analyzed the treaties signed by ten tribes of the southeastern tip of Vancouver Island and James Douglas in 1850. Duff argued that these documents contained insights into, as well as distortions of, the pre-contract environment of these Indians. Duff compared his own findings regarding specific places in the Songhees' territory prior to the construction of Fort Victoria.

The most recent, comprehensive study of the Songhees people and their land was done by Kanakos in 1982. She traced the resettlement issue of the reserve from 1843-1911, made an analysis of the influence this had on the man-environment relationship. The historical perspective of the land's claim issue provides the background to understanding the unique and intimate geographic, social and political position of Native and non-Native cultures in the Victoria area.

None of these studies documented the daily activities of women nor the beliefs and practices important in the childbearing period. In fact women were to a great extent ignored in these studies.

Context

Although the Songhees are in many ways similar to their Straits Salish cognate bands, the geographic location of the reserve and the history of its relocations contributes to a uniqueness of the Songhees which is reflected in their social organization and economy. Hill-Tout found in the early 1900's that the comparatively long contact with the whites who settled in their midst in the 1840's had already resulted in modified lives and customs and that the present generation knew little of the life and conditions of their forefathers (Hill-Tout, 1978). He goes on to state that

> ---indeed, of all the Salish tribes of British Columbia, I fear (the Lekwugen, Songhees) have benefitted least by contact with a superior civilization. Alcholism and all that follows in its train have wrought sad havoc among them both phsically and morally (Hill-Tout, 1978: 128).

Many changes had already taken place since the initial ethnograghic work was done by Franz Boas in 1888-9. The Songhees had experienced, indirectly, the European presence on the coast for numerous decades and with the construction of Fort Victoria in 1842, the Songhees came into direct contact with a culture very different from their own. Kanakos (1982) concludes that the contact experience was an event which led to adjustments in the Songhees relationship with their environment and changes in their culture.

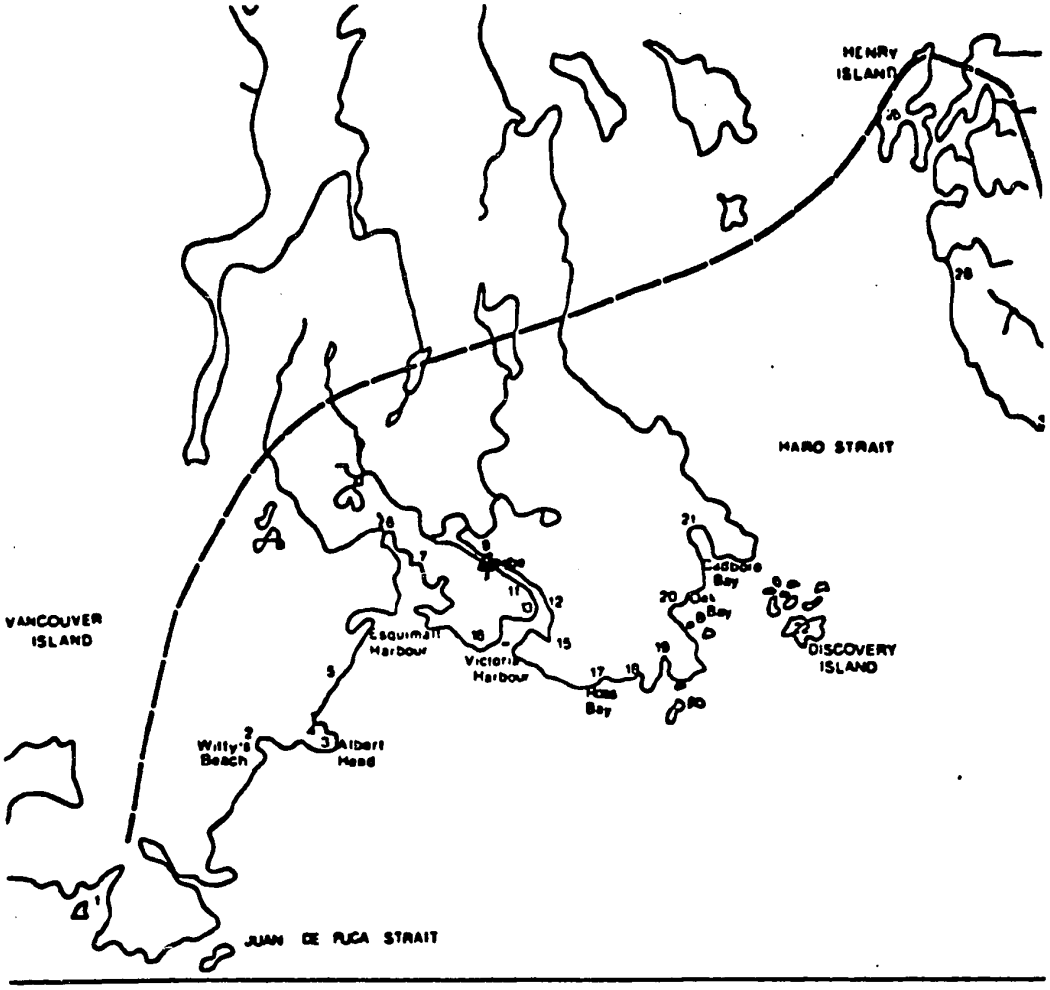
For more than a century now, the songhees people have been surrounded by a non-Native urban setting. During this period they have been forced to relocate several times to accomodate the European-Canadians. Their native neighbours to the north and west, however, live on reserves located within their original territory and continue to be exposed to a more rural existence, with less intense contact with non-Natives.

Location Relocation

The Songhees, known also as Lekunen, Swengwhung or Lekwungen, originally inhabited the eastern tip of Vancouver Island from Cordova Bay to Parry Bay, Discovery Island, and the western shores of Henry and San Juan Islands. (Map 4: The Songhees Territory). The winter Villages were found at what is now the Parliament Building, Deadmans' Island, Ross Bay and Clover Point, McNeil Bay, Cadboro Bay, Oak Bay, Willow's Beach, Discovery Island and Henry and San Juan Islands (Hill-Tout,1978). These permanent winter villages were comprised of several longhouses which were vacated temporarily during the summer when the people would set off by canoe to summer

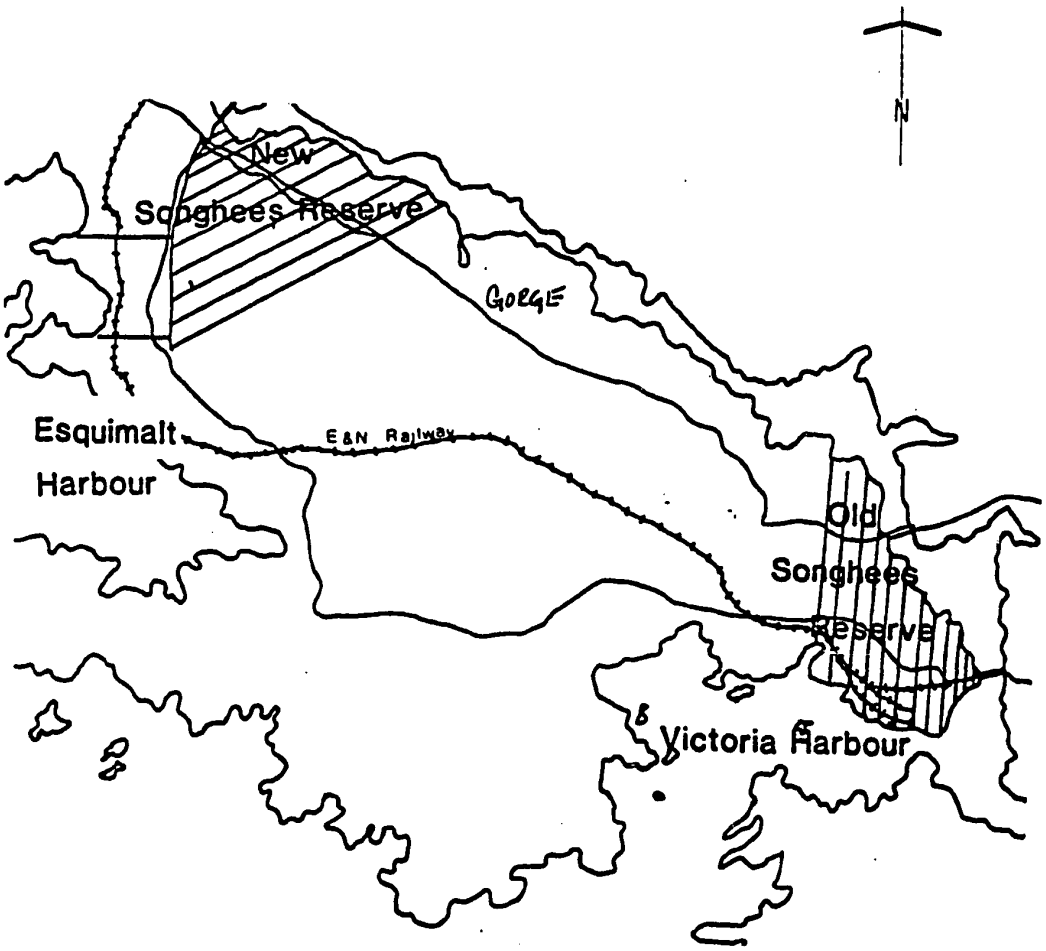
Map 4

The Songhees Territory



The Songhees' Territory

Map 5
Old and New Songhees Reserves



locations. All the winter sites were inhabited at the time of Fort Victoria's construction.

On June 28th, 1842 a resolution was passed that changed the lives of the Songhees forever. On that day, the Hudson Bay Company chose a new site for its headquarters on the Northwest Coast, the southern end of Vancouver Island (Kanakos, 1982). James Douglas, a prominent Hudson's Bay Company employee, first made an exploratory trip to the southern tip of Vancouver Island, and then on March 14, 1843 he returned to the Island to build a fort. The fort was to be built in the middle of the Songhees Territory of winter camps in Victoria Harbour. (Map 4: The Songhees Territory). When the fort's construction began, the "Swengwhung"or Songhees amalgamated and moved to a site at the northern perimeter of the fort. (Map 5: Old and New Songhees reserves).

Although the presence of the fort caused changes in the Songhees relationship with the environment and their culture, they adapted to the European presence in their territory. Their initial response was accomodative, although as settlement increased and the colonial government became increasingly dominant, the Songhees altered their position. After examining the land negotiations Kanakos (1982) concludes that the Songhees agreed to a peaceful resolution of this first government relocation issues, moving to the other side of the harbour, to avoid a confrontation previously experienced. However, this was also the beginnings of the strained relations between the Native and government peoples (Kanakos, 1982).

During the gold rush, the Songhees territories became densely populated and limited access to their resources became an imminent reality. The Songhees people learned that the treaties signed with Douglas did not guarantee unoccupied lands for hunting and fishing. The seeds of the Songhees resistance were sown, and their intransigence regarding relocation was to frustrate federal and provincial governments for the following forty years (Kanakos, 1982).

After the founding of Victoria, first called Camosun, after the Indian name of the 'rapids' on the Gorge, the Natives flocked into the harbour and settled at what is now the foot of Johnston Street. This became a populous centre, so populous, indeed as to inconvenience the colonists; and Governor Douglas induced them to cross the bay and settle on the other side (Hill-Tout, 1978). The practice of leaving the villages in the summer may have been perceived by the colonists as a form of voluntary relinquishment of these territories, as the Songhees did not always return to their previous village sites (Kanakos, 1982), but for the Native peoples it was a temporary departure. For instance, some groups amalgamated at Cadboro Bay, and at the same time they shared the surrounding territory. The implications of moving from the winter villages (Map:4 The Songhees Territory) were probably not apparent to the Songhees who had their own notions of land use and ownership. The Native-initiated amalgamation of village sites did not signal diminished access to the abandoned territory or its resources to the Songhees people. Uninhabited villages were still considered by the Songhees as belonging to their band.

After British Columbia joined Confederation Indian Affairs became a federal responsibility. Attempts to relocate the amalgamated Songhees Indian reserve lead to a jurisdictional dispute between the federal and provincial governments regarding title to the Songhees reserves. From 1871 until 1895 interest in the relocation of the Songhees removal stemmed primarily from a concern for the negative effect that the city had on them. Liquor and prostitution, combined with numerous occurrences of violence, were cited as reasons why the Songhees should be moved (Powell, 1880). The relocation of the Songhees was also considered desirable because of the barren terrain of the city reserve. The Superintendent of Indian Affairs for British Columbia, I.W. Powell, proposed a move to a more arable tract of land. He believed that an agriculturally based economy would improve the quality of the Songhees lives. Powell proposed various sites, but the Songhees were neither interested in moving nor becoming farmers (Kanakos, 1982).

Between 1871 and 1910 the Songhees were approached on numerous occassions to move their city reserve. According to the Indian Act, the Songhees agreement to surrender was necessary to complete a relocation transaction. The Songhees consistently refused to move from their reserve. They did not want to take part in any land negotiations until previous land agreements were concluded. Besides this longstanding grievance, the Songhees did not want to leave the city because of the amenities this location provided for the Band.

As the advantanges of the location eroded, the Songhees resistance to move wavered. The Songhees eventually agreed

to move in 1910. They realized that federal and provincial government officials, commercial interests and Victoria residents were determined to remove them with or without their consent. The Songhees consented to the move on certain terms, namely a large cash settlement. Despite the mood of urgency which prevailed, the government met the terms requested by the Songhees. Through their active role in land negotiations for over a half a century, the Songhees were able to negotiate terms which in some measure reflected their own needs (Kanakos, 1982).

In 1911 a deal was formally negotiated between the two governments. In return for the clear title to the new reserve the federal government agreed to pass special legislation which would allow the deal to proceed as stipulated by the Songhees (Map 5: Old and New Songhees Reserves). The Songhees Bill ratifying the agreement between the province and the Songhees was passed by the federal parliament on April 15, 1911 (Victoria Daily Times, 15 April, 1911:1). This bill allowed the Songhees families to be paid individually and in cash for the reserve. They were also paid for improvements of the old reserve. The title to the reserve, known as the "McCullum property" and owned by the Hudson's Bay Company, was forwarded to the federal government. The Songhees dead were moved, excepting those who had died of smallpox. On May 15, 16 and 17 of 1911 the major portion of the reserve was auctioned to the public (Victoria Daily Times, 17 May, 1911). Several acres were retained for the Esquimalt and Nanaimo Railway and The Canadian Pacific Railway, and an acre was allotted for a park.

The new reserve site in Esquimalt possessed geographic, social and economic advantages. It was adjacent to the "Esquimalt" Songhees family's reserve and was within the precontact territory claimed by the Band. The reserve possessed protected water frontage and was accessible to the areas to which the Songhees migrated in the summer. Employment existed in a cannery and sawmill and Esquimalt was linked to Victoria city by road (Kanakos, 1982).

The Songhees reserve remains in this location today: bordered on two sides by main streets leading to Esquimalt and Victoria and on the third side by the Gorge water. Several industrial plants, including lumber and cement, are adjacent on Admirals Road leading to Esquimalt, while the road leading to Victoria is primarily residential, with a large townhouse/condonminium complex bordering the reserve. Only 20 km from the centre of the city, the reserve is also close to shopping malls, recreation centres and other urban amenities accessible by public transportation. Within the reserve lands is a mobile home development. The land belongs to a Songhees family and is leased to the owners of the mobile homes. The only road that is paved is that part servicing the mobile homes; all others leading off the two main streets are pot-holed and gravelled. The reserve is serviced, however, with hydro-electric power, water, sewage disposal, and rural-route mail delivery. There are no schools, day care, health or medical care facilities on the reserve. Children attend Victoria municipal elementary and high schools; medical care is sought from physicians known to be taking, or sensitive to, Native patients and who practice in one of the two city general hospitals; preventive services are provided by a municipal community health nurse whose district encompasses a primarily non-Native population, and

a band employed Community Health Representative originally of the Kwakiutl tribe; and social services are administered by a band employed social worker from the Songhees reserve.

Resources for Subsistence

The numerous habitation and resource sites in the Songhees' territories indicated Songhees' precontact land use and land ownership. Winter villages were owned by families who built and occupied them, while resource sites were owned by those engaged in nearby reefnetting activities. The rest of the territory was shared amongst the Songhees and their Straits Salish neighbours.

Similar to other Coast Salish peoples, the Songhees relied on fish and seafood, supplemented with berries, fruits, roots and bulbs for subsistence. Small game and birds added variety to their diet, but the salmon remained the most important and respected food (Hill-Tout, 1978). There were extensive seasonal movements for salmon and berries during the summer. Some of the harvest was preserved by drying and smoking for later consumption during the winter. Unlike other Straits Salish people, the Songhees had separate and exclusive fishing, hunting, root and berry grounds (Hill-Tout, 1978).

The Songhees temporary summer camp sites generally corresponded with the Songhees reefnetting locations. Most of these sites, owned by specific families, existed on San Juan Island (Suttles, 1951). Reefnetting was a method of fishing that was the speciality of the Straits Salish. Dependant upon unique geographic features, reefnetting influenced technical, religious and social facets of the

Songhees culture. The technique of reefnetting were based on a knowlege of the migrations of the sockeye salmon through the Straits where the particular topography facilitated this type of fishing (Suttles 1951). The fishing procedure, like most other food gathering activities of the Salish was accompanied by rituals. Specific ceremonies were presided over and organized by the chief who owned the fishing site. Salmon themselves possessed a spirit which was revered. Special care was taken when killing and drying the salmon so that the salmon's spirit was not offended (Kanakos, 1982).

Fishing was done by men; while women and children assisted with cleaning and drying salmon. A reefnet site owner could recruite from all the tribe. Productive sites were popular and there was competition amongst the Songhees for work at these sites. In return for the labour supplied at the fishing site, families received food throughout the fishing season.

Though reefnetting was the most important economic activity, the Songhees travelled to many other food sites, expecially in the summer. The Songhees, like their Straits Salish neighbours, adapted their migratory patterns to the availability of particular food sources at specific time of the year. Sites were frequented in a particular order depending on which berries, rushes or roots were in season.

They continued these traditional migrations to gather food and resources for three decades following the establishment of Fort Victoria. Eventually, however, the European-Canadian settlement encroached on the resource environment

to such an extent that traditional food availability was severely curtailed. This, combined with a new economic system intimately connected with their European neighbours, diminished the fishing, hunting and gathering activities of the songhees people, and replaced the subsistence activities with purchasing and trading powers for non-Native food subsistence.

Of all the traditional Native foods, the salmon remains the most important one for the Songhees. Prepared in a variety of ways, it is also served on special occasions, at ceremonies or to commemorate significant events. One is honored when a special piece of smoked salmon or boiled fresh salmon accompanied by fried bread or bannok is produced for the meal. Like most North American people, it is unfortunate that the diet is now substituted with non-nutritious and convenience foods. For many this forms the bulk of the diet, as time, motivation, access, taste preference and necessary skills to obtain and prepare "Indian food" have been lost. However, interest in resuming a diet containing Indian food has resulted in some women on the Songhees reserve using a Native cookbook which records some of the historic aspects of subsistence from the few elders who remember "the old ways". Families are being exposed to Indian food in a new way and encouraged to include it in their diet. A nutritionist working with Medical Services Branch of Health and Welfare Canada has produced charts comparing the nutritional values of Indian foods with those of the North American diet. They clearly show the superior quality of their natural food resources.

Housing

The winter villages were important in the lives of the Songhees. The longhouse, or "big house", provided safe and warm relief during the winter season. Inside the "big house", through dance and celebration, the spirit came alive with the sounds of drums and chanting. Here, near the warmth of the fire, Songhees families passed the winter months, sharing traditional beliefs and stories and tales of daily adventures.

Mobile home trailers, bungalows, and small houses now replace the longhouses. However small or large, furnished or unfurnished though, the house becomes home for extended family members. It is not unusual to find members from three generations sharing close quarters, family responsibilities and available resources.

All housing is supplied by the Songhees Band and application must be made to band Council for a change in residence or repairs and renovations. Band monies and labor fall short of requests and thus priorities are made, not always to everyone's satisfaction. Some projects which get initiated may not see completion for a number of years and families cope with a variety of housing situations, most of which are inadequate for their needs.

The homes are generally located off the two main roads and up a hill. A large open field is at the base of the hill, available for softball and other games. The Band office, located on the boundary of the reserve in a old school, houses the Band-empoyed manager, social workers and community health representative. Because there are no

longhouses, big houses, or churches on the reserve, the Band office also serves as a gathering place for Council meetings, social and educational activities, christenings, child health clinics and public forums.

Economics

While the Songhees might not have welcomed the Europeans in their territory, they did not attempt to deny them access through armed resistence. The Songhees were probably aware of the benefits that might eminate from the existence of the fort in their territory. From the village adjacent to the fort, the Songhees planned to control trade. they intended to be the "home guards" and attempted to act as middlemen between the Indians and the company traders (Kanakos. 1982).

At the new Sungwhung village site at the northern perimeter of Victoria Fort, there were numerous opportunities for employment. During the fort's construction the Songhees exchanged pickets for blankets. From as far away as five miles, these Indians hauled pickets measuring twenty-two feet in length by three feet in circumference. In return for forty pickets, they received one blanket (Kanakos, 1982). The Songhees also assisted in the Hudson Bay company's agricultural activities, plowing fields and planting potatoes. They also supplied the fort's residents with salmon and buckets of clams, acted as guides, and delivered the fort's mail by canoe (Suttles, 1951).

The proximity of the reserve to Victoria was an important ecomonic benefit for the Band, and perhaps the most important advantage of the location. The Songhees'

successful adaption to the existence of the fort's economy was established in the early settlement era and continued to be related to the city's economy after 1871 (Powell, 1880). The Native people combined their city jobs with traditional migrations for food. The majority of Songhees men and women travelled in the summer to the Fraser River, where they fished or worked in canneries. Other Songhees, in search of employment rather than traditional food sources, travelled to Washington where they picked hops and berries (Kanakos, 1982).

Most of the Songhees people today are reliant on employment in non-Native settings. Unemployment is a continual battle, as the educational and skill level of the members is often less than their non-Native competitors. Many men and women have jobs that are either temporary or subject to lay-offs due to strikes or seasonal availability. Employment off-reserve ranges from teacher to gas pump attendant, from janitoress to convenience store owner. Several are employed by other Coast Salish bands, such as the Cowichan and Saanich; others find jobs with logging or fishing companies with requires extended absences from the reserve. Band employees include health and social care workers, manager, and others as required for special mantenance, office or summer jobs.

Similar to other bands, the Songhees Band receives monies from Indian and Northern Development. The amount is based on membership as well as school allowance for children attending municipal schools. Other income for the Songhees comes from land leased for the mobile homes. Since no treaty was signed with the provincial or federal government there is no treaty money. Wages earned in

non-Native employment are subject to income tax, but those earned on reserve are tax free. There is no land tax on the reserve.

Recently some members of Band council have been considering the possibility of operating a smoke house and cannery on the reserve. They would combine traditional foods and preservation with some contemporary facilities and market, and employ Songhees Band members. The Songhees Band, while not considered to be affluent, is in some ways better off that other bands of similar financial resources because of its proximity to the city and good transportation routes to cognate bands.

Lifestyle - Culture Change

The daily life of the Songhees traditionally varied with the season of the year. Successful fishing and an abundant harvest was critical for an adequate food supply during the winter months. A busy summer and autumn life of hunting and fishing for men and preserving and gathering for women was replaced with a more relaxed, winter life, feasting on the fruits of the harvest and enjoying time for games, entertainment and spiritual ceremonies and rites.

The climate was mild and pleasant throughout the long summer and not very severe during the short winter. Fish, game and wild fruits abounded, so that the Songhees incurred no danger of famine as long as they exercised forethought and gathered in the harvest while it lasted. However, this was not always the case.

The construction of Fort Victoria in the center of Songhees

territory challenged the Songhees' traditional relationship with their land by offering alternative sources of income. In the presence of this challenge and the accompanying threats of alchohol and disease, the Songhees continued hunting, fishing and resource gathering to some extent, while trading and accepting work at the Fort. They appeared to respond in an accommodative manner to European penetration into their territory. However, employment meant that less time was available for previous forms of resource exploitation. The exchange of Songhees labour for goods, particularly blankets, affected their once necessary migrations to gather reeds for textiles for clothing and protection. Changes to their migrations affected by changing food supplies also altered their social and spiritual activities.

The struggle between Native and white systems of behavior and belief in everyday life is evident today in their attempts of gaining employment and service in the non-Native society, while requiring recognition and respect of their distinct cultural needs. For those following Native customs, attendance at rituals and ceremonies and adherance to the required disciplines is paramount. These beliefs and values often conflict with the work ethic of the Canadian culture. Extra days off are not usually an acceptable alternative to the employer. Conflicts and struggle have led some to renounce Native ways; others look for alternatives to the white system, showing their disapproval or disdain in ways that are at time socially unacceptable in either society.

Seasonal migration no longer takes place, but several elders told how they had travelled to Washington State as

young girls with their mothers and grandmothers to pick strawberries. Until the employment of migrant workers, this was an important summer event and economic endeavor. It brought extended family and related kin together as they set up summer camp, prepared meals and parented children in a way that increased the efficiency of their berry picking.

Although migration no longer marks the seasons, cultural and spiritual ceremonies and customs do. Winter is the time for the Winter Ceremonials and Dancing, while summer activities mean team sports and canoe races. Both summer and winter activity participation requires good physical condition and mental stamina and prohibits the use of alcohol. Although members who violate this may be refused entry into the Longhouse or participation in the ceremonies, the most usual treatment is for a family member to take them aside so they are not publicly shamed.

The Songhees people did not escape the stereotyping or discrimination aimed at other Native people. Besides the legal aspect of Indian status after the Indian Act was passed and the revocation of prohibiting alcohol sales to Native peoples in 1954, some beer parlours refused admittance to Native women and their escorts, and some washrooms were designated according to cultural background (Lewis, 1970). Innuendos of discrimination occur today in employment opportunities, service in restaurants and hotels and access to health and social services.

On one occasion when the investigator was lunching with a Native male, they were ignored by any service person for the first half hour, then given minimal, cursory service after requesting a menu. Numerous stories were recounted

by Native families of the discriminatory service given in hospitals and medical facilities. One mother described an experience of visiting the emergency department in one hospital in the evening, being told that her daughter's problem could not be dealt with there, and "anyway it doesn't sound like it is something that has to be looked after right away". They were told to go to the other general hospital, about 10 miles away. When they got there they found the other hospital had phoned ahead, warning them of their arrival. The daughter was treated with such disrespect and disbelief that she left in tears, not waiting for examination and refusing further humiliation. The next day her doctor admitted her for severe cystitis in her seventh month of pregnancy.

Another Songhees woman, university educated, confirmed others' suggestions that they were treated differently in department stores and super-markets. She told of being followed down the aisles in a supermarket by plainclothed company security persons, who watched her every time she reached for something on the shelf. "We are always watched more closely than anyone else - guess they think we are going to steal or destroy their stuff".

Ceremonies - Rituals

Suttles (1955) remarks on the uniqueness of the integration of myth, social organization and religous practice among the Coast Salish. The plots and incidents that exist in the myths still recounted offer a coherent explanation of social and ceremonial practice. Although not within the scope of this study, it was noted that Native students were

being encouraged to learn the myths from their elders and record them as school assignments. One outcome of such an endeavor was publication of the book "Tales From the Longhouse" (Indian Children of British Columbia, 1973). Another project involved Songhees students and elders during the summer. Their task was to recount not only the myths and legends, but to recall and record traditional practices related to lifestyle behaviours, including the consumption of alcohol.

Even though the structural facilities for worship and ceremonies do not exist on the Songhees reserve, the peoples are active in Longhouse activities and winter ceremonials, games including team sports of softball, lacrosse and soccer and summer canoe racing, bone games and gambling. Much travel occurs during the winter and summer seasons as the Songhees people and teams participate in the events which are organized on a rotational basis throughout the reserves on the Straits Salish and other Coast Salish Bands. Most canoe racing competition occurs among the Straits Salish on weekends from May to September, while it is not unusual to hear of softball and soccer teams going over the mainland for weekend games from April to October. Winter cermonials and dancing now start as early in the year as November, and continue to March. Through these months dancing is held by various bands along the coast of south Vancouver Island almost every weekend, with up to 1000 people in attendance. Almost every night during the week in summer the teams work-out and practice and in winter initiates and their sponsors dance in their own village.

The weekend dances provide occasions for many of the social

ceremonies which were originally performed as Potlatches. Several such occasions occurred during the 1983-84 season. One was sponsored by a family honoring dead members of that family; another was held to confer an inherited Indian name on the some of a well-known chief and dancer. As both Duff(1964) and Jilek(1978) report, there is little indication that spirit dancing will die out within the near future. On the contrary, it gives the impression of being a flourishing and still evolving activity. Some of the reasons for this are that it may be therapuetic for socially unacceptable behavior, provide profound sensations which are fundamentally spiritual in nature, enhance feelings of dignity and importance of social security of belonging to a special group, give status satisfaction to all active participants, be a means of expressing Indian identity and cement kinship ties locally and beyond (Duff, 1965; Jilek, 1978; Lewis, 1970).

For some Songhees families, ritualized observances around the first menstruation are practiced. Although reportedly not as strict or rigorous today, the spirit quest requires discipline in early rising, doing daily household activities, adhering to cleanliness and hygiene norms, isolating oneself and learning certain precious songs, rites and knowledge taught by mothers and grandmothers. The rituals marking the girl's puberty culminate in a great feast, distribution of gifts and exhibition of family privileges in song and dance. Hill-Tout(1978) reports that at the turn of the century the song-dance was usually a more or less dramatic presentation of some event, real or fancied, in the life or history of the girl's ancestors, probably that which gave rise to the name which is going to be bestowed upon her. After the demonstration of the

family privileges, the father would call a number of Native leaders from among the guests to act as sponsors or witnesses of the bestowing of the name, and after the ceremonial name giving, these formal witnesses were given gifts. The newly acquired name is used on special occasions and always within the Longhouse. The practices exist today in various degrees of strictness and comprehensiveness; while the ceremonies continue to be important in the lives of some families. During the research period several young girls who were being instructed by an elder but had not been given a cerenomy; whereas an invitation had been received by Songhees people to attend a Potlatch in Port Alberni to witness the transitional stage of the life cycle of a young Coast Salish woman with the bestowing of a titular name.

Most of these tribal gatherings continue to be festive occasions, opportunities for feasting, visiting, re-establishing Native values, and having fun. Special occasions are marked by invitations to whole bands and each member feels some responsibility to attend. Not all do, of course, but those that attend are not hesitant in acknowledging their "Indianness" and way of life.

Religion

The Shaker Church represents a blend of Christian and Native beliefs. It is a Christian Church of Native origin; its congregation is Native and its attitudes and rituals have a distinctly Indian flavor (Duff, 1965; Amoss 1972). The history of this church has been told in two excellent studies by anthropologists (Gunther, 1949; Barnett, 1957). It was founded by John Slocum of the Squaxin tribe in the southern Puget Sound area of Washington in the 1880's. It

is reported that in 1881 or 1882 he "died" and after some hours returned to life. He said that he had reached the gates of heaven but had not been admitted because of his sinful life, and that he had been given, the mission of preaching to the Indian people so that they might get to heaven. He asked that a church be built and before it was completed he began to preach. Some time later he fell seriously ill again. His mourning wife suddenly began to tremble violently as she cared for him and the "shaking" seemed to help bring about his cure. It was adopted by members of the church as a supernatural gift of God, and sessions of shaking over sick persons to cure them became one of the main activities of the church and gave it its name. The healing ceremony is known as a "shake". The Shaker religion prohibits drinking and smoking and requires regular practice for the spirit or power to be maintained by the member.

The church found members in Victoria shortly before 1900, and churches were built at Esquimalt (Songhees), West Saanich, and Duncan (Duff, 19650). The Saanich and Duncan ones are still standing and being used but the Songhees one burned down many years ago. The buildings are simple and stark, furnished with only a prayer table and benches along the wall. Services, which may extend from Friday night through Sunday, include processions with bells and candles, hymn-singing, prayers and brief sermons. Home altars are common and are similar to that of the church: table with white cloth, candles and bells, homes are sometimes used for services when Songhees people do not want to travel to one of the other reserves.

Remnants and modifications of the Native religion are practiced today by the Songhees in some ceremonies, spirit and masked dances and sweat lodges. The beliefs and practices from the old way of life, which were religious in the broader sense of the term (beliefs in supernatural beings and forces, and practices for dealing with them), still persist, but are not considered to conflict with Christian religion.

The spirit dances of the Straits Salish and Songhees were intensely spiritual in nature, since each dancer had her/his own individual guardian spirit which possessed her/him during the dance (Duff, 1965). Some of the spiritual meaning may have been lost, but the spirit dancing is still practised and provides the Songhees and other Coast Salish peoples with experiences which are in the broad sense religious.

Besides the religious function, the spirit dance has a social function of maintaining integrity and conhesiveness of the Native groups, as it is an exclusively Native practice and intensifies the personal links with other Coast Salish (Amoss, 1972). Its time and cost demands are heavy, but it strengthens commitments to the ceremonial network and Native culture, and reconciles contraditions between essential values. The individual functions include securing recognition, expressing spontaneity and creativity, affirming identity, establishing membership in a definite human group and belonging to a moral order. These are considered to be basic strivings of all individuals (Amoss, 1972).

Inititaion as a new dancer occurs usually in the late teens or early twenties, still requiring strict diciplines to acquire a supernatural power and guardian spirit. Initiation may be voluntary, but on most occasions the candidate is "grabbed" by family members and forced to enter the Longhouse. In some instances, the reasons have been to teach socially and culturally acceptable behaviour. Problems with alcohol use are viewed as good reasons for "grabbing". In a few cases the power has entered the individual earlier in life, but more often it is acquired during the initiation. The power brings with it distinctive personnel variations in the song, dance, costume and pattern of painting the face. Both recent initiates and sponsors confirmed Duff's findings (1965) that for four days, while these are being learned or sought, the new dancer undergoes special rituals and observances to help her through this important period of transition. For the remainder of the dancing season she is expected to live in the Longhouse, wear a special costume, and observe certain other rituals (Duff, 1965). If employed off the reserve, after the first couple of weeks she may resume her job, but return to the Longhouse at night. Sponsors and teachers have responsibilities every night during the week to help their particular initiate. For the Songhees without a Longhouse, initiation and Longhouse activities take place on a neighbouring reserve.

One Songhees family also talked about another winter ceremonial locally known as the "Masked Dance". This is a secret society with membership restricted to male (although females can pass on the mask, they cannot dance) members of the family, usually the elder ones. The oldest male inherits the right to perform the dance which must be

learned from his father. If something happens to this candidate, it is up to another male sibling to request the honor of learning the dance. It is the responsibility of the family to determine his suitability. The Masked Dance is traditionally family-specific, but may on occasion be shared with other families related through marriages. Another elder told of how her father learned the family dance from a family at Lummi many years ago when the families were first joined by marriage.

At a 1983 "pow wow" in Saanich, where Native dancers from western Canada and the northwestern United States gathered and participated, the Straits Salish peoples announced that, due to the deeply religious aspect and spiritual meaning of their dances, they would not be performing these dances, nor would they be wearing the dance costumes, even though they would participate in their neighbour's dances. Duff suggests that these "pow wows" and similar "Indian Days" held in some British Columbia communities are examples of "neo-Indian culture" which provides occasions to enjoy renewed social contacts and gain recognition as Indians (Duff, 1965). Thus they have similar function to winter ceremonials and summer canoe races.

The most elaborate Songhees ceremony was the Potlatch. A Potlatch was usually sponsored by a chief, who decided which of the neighbouring tribes would be invited. During the ceremony, the hosting chief was raised on a scaffold while his son or daughter danced, then the gifts were distributed. The distribution could take three or four days and was interspersed with games, dancing and eating. Today, extended family members all participate in the planning and sponsoring of the Potlatches, preparing food,

making gifts, performing songs and dances and witnessing the occasion.

Potlatches play a significant role in the contemporary ceremonial life of the Songhees, rather than in the economic system as was the traditional role. Although no Potlatches were given on the Songhees reserve in 1983-84, reports of attendance at one in Saanich confirmed their importance. The occasion was to assist the soul of a recently deceased family member depart in harmony and to provide support to the family experiencing the loss of their elder female. Members from all neighbouring bands were invited and the assistance of a Songhees elder with special clairvoyant powers was engaged to intercept and interpret messages, not only from this family member but other deceased family members. She led the family in various rituals, one of which involved the burning of special clothes that would assist the departed soul. A son of the deceased elder spoke of the significance of the work of this powerful person and the witnessing of the guests as critical to accepting the death and knowing that all had now been done that could be done to assure a safe and happy after life for the deceased and peace of mind for the family. The guests were fed and given gifts in recognition of their witnessing and acknowledging of this event.

Art/Games

Carving in wood and silver and knitting Cowichan Indian sweaters are the major forms of art among the Songhees people. The art of weaving baskets has not been renewed and few elders know where to find the required reeds. Most of the homes display some form of Indian art, family

photographs and knitting in various stages of completion. The market for the arts is found in Victoria stores, private/commissioned sales or in travels around the province.

All-Native male and female teams are active during the summer playing softball, soccer and lacrosse and "pulling" (paddling canoes). Weekday practices with Native coaches prepare the Songhees teams for week-end games and end of season tribal competitions. During week-end canoe races, families camp at the designated water site, participate in the game, sell food and crafts and visit with family and friends. Bone games (Slahal) and poker, accompanied by spectator betting and Native drumming and singing, are popular side-events of the canoe races. Much money is lost and won. The canoe races, which are attended at times by a few non-Natives, have some of the aspects of modern festivals (camping, sports contests, snack stands), but also some of the feeling of old-time Potlatches (Duff,1965).

Gatherings at winter dances, summer canoe races and Potlatches, bringing together large numbers of Straits Salish people, are occasions for much speech making in the Native languages. The speeches make reference to ties of kinship which hold the people together exhort the young to respect the memories of ancestors who were previous owners of their honored names, and encourage all peoples to maintain old traditions. Native prayers in the Native language usually precede the opening of any gathering.

Morals and values

As previously mentioned, myths, legends and stories were primary means of transmitting beliefs, attitudes, and knowledge from one generation to the next. This was traditionally the responsibility of grandparents, as they were respected as the wise and knowing elders. Among the Songhees there are only a few who qualify for the term "elder" by age, but several who are referred to as such because of their knowledge of Native ways, wisdom gained with experience and power achieved through quest and disciplines.

It is the elders and grandparents, whose status is achieved with advanced age and achievement, who continue to sponsor important ceremonies and oversee activities that demand careful attention to regulations. They take charge of important ceremonies, such as those for the dead, and maintain important positions in the extended family. Although in many instances, the grandparents do not live in the same house, their home is an extension of their children's home, as they act as the caretakers and trainers of children and grandchildren, guardians of family tradition and geneologists of family relationships. Myths and legends appear to play a less dominant role today, but the teachings are deemed important throughout the lifecycle and especially at transitional stages. "When the time comes, and it is right, that's when I will tell her" one mother said about her daughter' first pregnancy. Grandparents continuously and repetitiously teach the children about who belongs to the family through blood and marriage, as these relationships can be very complicated. The purpose is not only to given them a sense of family

identify, but to inform them of relationships that would not be acceptable for marriage.

For one young boy who was just approaching puberty, it was the grandparents who were arranging for him to spend time with a wise Native of the Saanich bands to learn the Native ways and disciplines. This Native teacher, a young man by traditional standards, was respected for his knowledge of the beliefs, customs, language and spirit power. He told of how he would not only instruct the boy in the discipline necessary to acquire his own guardian spirits song and dance, but how this also allowed him to renew and strengthen his own spirit. The disciplines included fasting, daily bathing in the river or ocean, spending time alone in the woods and listening to the teachings. Both physical and mental stamina are tested in the training; a combination of instruction (verbal explanations and moral lectures) and carefully designed ordeals (Amoss, 1972). Individuals also need the cooperation of their families in order to display the guardian spirit: the support to put on a party, training and instruction and the social sanctions to butress the supernatural system.

Not all young people go through this rigorous experience; others are "grabbed" into the Longhouse and subjected to the initiation disciplines; others are instructed by mothers and grandmothers (for the girls) to take on new responsibilities in the home and give up the free life of a child. Many of the chilbearing women recounted their own experience at puberty when their mother made them get up early, scrub the floors, learn household skills and give up playing with the boys.

However, many of these same women feel that now, as parents, they do not have enough knowledge of the Native and Songhees ways to be teaching their children and grandchildren. Their stories confirm reports for West Coast Natives in general; residential schools severely interrupted the transmission of cultural content and history between one generation and the next. Some childbearing women who had been sent to residential school are now trying to learn some of the Songhees ways, even the language, so they can be respected as teachers when the appropriate time comes. But as parents they are also in some instances the older members of the band, and there is concern that the traditional knowledge and advice will be lost forever, as the few "real" elders die before they can teach enough. One elder told how she was "taping" as much as she could remember for her son who was interested in learning the ways and language, but that she was afraid that she had already forgotten a lot. As one of the eldest in the family, she did not have older family members to confer with for validation or supplementation.

At the same time of wanting to learn more about the Native ways, however, the women experience a sense of cognitive dissonance as they consider the "advice" of the elders in light of the contemporary Canadian practices. One mother called them "Old Wive's Tales", another supersititons; but both said that they shared the advice with their daughters even though they were not adament about them following it rigidly. The advice was given to govern behavior, as well as to provide explanations for outcomes. (These behaviors and explanations are discussed in Chapter 5).

While living at home, loyalty and respect are expected for the authority of the head of the household. However, some of the elders consider these lacking or inadequate in many of the young peoples' relationships with their parents. "They want to try the white man's ways and live like them" commented one elder. In some of the crowded housing conditions on the Songhees reserve, children see and share in essentially all sides of the lives of their parents. There is little attempt to hide anything; from liquor bottles to sanitary napkins. There was an exception to this, however, as one informant described getting up early in the morning to clean up after a party so that her daughter would not see the remains. She stated that she did not want her daughter to grow up being influenced by alcohol, as she had seen the results in other children on the reserve. Generally children are all too aware of parental conflict and are accepting as well as protective.

Kinship System

A great network of relationships has grown up on the Songhees reserve over the years. It is the close ties that have remained the most meaningful in daily living; those among father, mother, children, aunts, uncle and grandparents on both sides of the family. This large network of kin make up the individual's environment, bound through ties of blood and through ties of common purpose, resulting in affirmation of Native identity and unity. However, it has also resulted in attitudes of distrust of those not of close kin. Concern is also expressed regarding equal treatment when not a member of the Band chief's family. Several family-oriented disagreements with the Band counsil were reported and suggestions made that if

there were a different chief their family would fare better.

The kinship structure of the Songhees is similar to other Straits Salish bands. It is a network of valued relationships that interlink economic life and social organization, religious life and concepts and values. Bilateral lineage and patrilocal residence continue to be the norm.

Social Organization

The summer reefnetting activities had social implications for the Songhees. Reefnetting brought families together in close contact. Groups and individuals, who otherwise might not associate throughout the year, participated in the religious and social ceremonies related to this subsistence activity. Social relationships developed and marriage alliances were considered. The possibility of spontaneous social interaction was probably greater at this time, than during the winter season (Kanakos, 1982). This no doubt laid the foundation for the present day relationships up and down the coast.

The Songhees spoke "Lakonenan". They shared this language with their immediate neighbours the Semiahmoo, Lummi, Samish, Klallam and Sooke Indians. They interacted primarily with these similar linguistic groups, although the Songhees became a separate political unit in the eyes of the Europeans with the signing of the treaties in 1850. The Songhees social contacts extended to other Coast Salish groups such as the Cowichan, Squamish and Musquam. These interactions took the Songhees out of familiar territory to

the Cowichan Valley on Vancouver Island, to the mainland coast and to the lower reaches of the Fraser River. Today maternal aunts, uncles, grandparents and in-laws are scattered up and down the coast. Frequents visits are made to the favorite close ones; whereas intimate daily contact is unusual between remoter relatives right at hand. Many people on the reserve have little knowledge of what is going on even in nearby households where there are no kin connections.

The nuclear family was the basic unit for sharing in production and consumption in the Songhees society. Families lived together in longhouses, with each family occupying a separate section of the house. The family groups living together were related by blood or by marriage through either the males or the females (Suttles, 1951). While each family had its own fire in the house, some of the food preparation was done communally. These families worked together in some major food gathering activities and participated as a unit in trading possessions, sponsoring ceremonies and defending the community.

Today, patrilocal residency predominates and family members work cooperatively, especially for sponsoring ceremonies and feasts. Their economic resources tend to belong to individual nuclear families, but no one is ever turned away or denied required resources if the resources are available.

Although not everyone on the Songhees reserve had an intact nuclear family, each did have a group of kinfolk. Family members come and go, but within the large network of the Band, the individual is cared for and expected to have a

share in the common experiences. Young couples move back and forth from family to independence. A few try off-reserve living since the city is so close, but generally they stay on the reserve. With the limited housing available on the Songhees reserve, it may not always be from choice that young couples move in or stay with parents, however. One young informant, her partner and baby daughter were living with her family of eight in a three-bedroom bungalow because she had not made application yet to the Band Council for a trailer, and when she did put in a request she had to present a good case for why the three of them should be given a place of their own. Her rationale was that she needed to learn to take care of a family by herself, without the help of mother and sisters in the house.

Rank

According to Suttles there were three classes in the Songhees' society. Similar to other Coast Salish tribes, the "high class" Songhees people were people with "advice" or "who knew how to behave properly". The "second class" people were poor people who had become rich, and the "low class" people were those without "advice" or those who had "lost their history" (Suttles, 1951). Boas called these classes the nobility, the middle class and the lower class and claimed that the lower class lived in the southern area of the Songhees territory (Boas, 1880). Today there is little evidence of these class distinctions, except in reference to the family name.

Wealth, power and knowledge were possessions which contributed to an individuals's or family's rank. Wealth

was acquired through the inherited possession of a productive food site and by way of successful hunting expeditions. Success on a hunting expedition was based on hunting expertise and the possession of hunting knowledge and powers. While upward mobility was possible through the acquisition of power and knowledge in vision and dreams, rank was usually established through inheritance of these possessions. Power and rank were validated by a display of wealth. The sponsorship of ceremonies such as marriage feasts and Potlatches provided an opportunity for this display.

In the past, the resources collected throughout the year were shared with the guests at the Songhees ceremonies. The resources accumulated formed the basis of a family's wealth. With a plentiful harvest a family was able to perform an ostentatious display of wealth, whereas in a lean year a display might be restricted. A limited supply of resources might reduce the social standing of a particular family or group.

Later a new wealth was available through the wage economy at the fort which influenced individual and group status. An individual displaying wealth accumulated through labouring at the fort could enhance both his own and his family's rank, which was traditionally based on ascriptive or inherited rights. Acquired power enhanced status and altered inter- group relations. Chiefs were considered high class persons whose noble position could be inherited. Today the reserve does not reflect status differences in location of houses. The property on which the house stands is "family " and can be inherited. What people do with with their place seems to reflect their economic status and

interest. The position of chief is now an elected one, with elections taking place every two years. The present chief has the distinction among the Straits Salish of being the chief holding office for the longest term -more than two decades.

Suttles points out that the most striking contrast in the Coast Salish culture is the contrast between the breadth of social ceremonial relationships that one small community, like the Songhees, may have with other communities, and the narrowness and intensity of its spiritual and economic relationship to its own small territory (Suttles, 1955). To a significant degree this contrast continues thirty years after his observations.

Kinship

Songhees marriages were arranged by the families involved rather than by the couple. Consideration was given to the need for village protection and hospitality and the opportunity for gaining desirable social connections. Marriage was the "primary alliance" between households and communities and care was taken to ensure that the status and wealth of the families was comparable. The ceremony included a display of wealth and an exchange of goods. In most cases women were recruited from neighbouring Straits Salish and Coast Salish communities. The reserve's location allowed the Songhees to continue intertribal social relationships and traditional patterns of intermarriage. Although the Songhees intermarried with their northern neighbours, the Saanich and Cowichan, as well as their southern neighbours the Klallam and Sooke, it appears that the emphasis of these relations was to the

south (Suttles, (1951). Contemporary situations suggest that marriages occur equally with northern and southern neighbours.

Marriages of close family members were not encouraged, but marriage beyond second cousins was permissable. If one partner died, then the survivor usually married a relative of the deceased, so that the familial ties the marriage represented were maintained. Many years ago, polygamy was practised, especially amongst males of high rank. In many instances, the male had wives in several villages therefore establishing ties with each group.

Although exogamy is now expected and arranged marriages are infrequent, marriage is encouraged among members of neighbouring bands. Many couples, not legally married according to the Canadian system, speak of their relationships as being an Indian marriage: a voluntary cohabitation neither marked by ceremony nor exchange of gifts. The partners express feelings of commitment to each other, although this appears stronger on the part of the woman; both partners expect that the outcome of their relationship will be having children. The Indian common-law marriage represents the persistance of an old system of marriage relationships and values that perceives the Native person as an individual who does what she thinks best, and is not to be dominated by the legal structures of the white man (Lewis, 1970).

Relatives on both sides are important in the extended family. Lewis (1970) states that this is required in cultures where "gift-giving" is an all-important mechanism that pervades the whole structure of society. Relatives

were, and are, important; none are cast off because of age, disability or membership on mother's side. Even those relatives at a distance continue to visit, help and teach. An elder Songhees woman, whose brother lived on the Cowichan reserve in Duncan, travelled the mountainous 90 kms daily for four months during the winter of 1983-84. Her brother's health was rapidly deteriorating and she felt responsible for being with him as much as possible, preparing favourite foods even though his wife lived with him, and arranging for healing ceremonies to be performed. She paid for a "powerful healer with great spirit" to come up from Washington to perform a four day and night healing ceremony after local "Shakes" were not as successful as they wished.

Role of Women

Women are not bound irrevocably to their husbands, although their families attempt to help them make the marriage stable. It is the norm to be living as a couple and to have children. For many of the Songhees women of childbearing age this remains their primary source of satisfaction and contribution to the community. Many women defer to their husbands, but not to the extent of losing their individualism and uniqueness. Their individualism is validated through spirit dancing, acquiring special power, participating at ceremonies and obtaining knowledge and skills valuable to the community. Several of the informants of chilbearing age had either gone on to complete their high school education or had taken courses preparing them to be nurse's aides, community health representatives, band managers or office workers. The elder women were more varied in their validation. One had become fluent in

English and Lekumen and had been previously employed by the Cowichan band as a home-school coordinator, a very critical position in the education of Native children. Another elder, whose daughters had all continued with some aspect of their education, spoke limited English and spent most of her time with her extended family and relatives, taking care of visitors and teaching grandchildren. She was also recording the Native history and language for her son.

Similar to the findings of Lewis (1970) in the 1950's and 1960's, the presence of men severely restricted women's participation in social dialogue or interviews. The tendency was to remain quiet or retreat and wait for the men to speak. However, when women were alone they felt freer to chat, share information and answer questions. There may have been hestitancy to do this in front of males if the topic was one strictly related to women's business, or was of a sensitive nature.

There may also have been some reluctance to be too involved with a white person lest they be perceived by other band members as "white lovers", helping and giving away private and privileged knowledge. Several times the arrival of an adult male family member curtailed not only the present conversation, but involvement in the study.

Knowledge and Beliefs

The Songhees shared a common world-view with their Coast Salish neighbours. Those groups possessed a world-view which depicted a spiritual relationship between man, nature and the supernatural. The Songhees envisioned nature as a source of supernatural powers, and perceived food as a gift

of the supernatural. Both supernatural power and food were greatly revered. Food was often described by a word which means "sacred" (Kanakos, 1982). As the Songhees moved over their territory and collected resources they did so with reverence and attempted to maintain positive relations with the living spirit in all things.

In their world view, man is set apart from nature and needs to establish lines of communication with the non-human realm to exploit the natural environment (Amoss, 1970). The basic assumption of the guardian spirit system is that it is possible for individuals to establish contact with supernatural powers through vision quests and experiences. The relationship between the person and the supernatural experience continues to demand cooperation and mutual support.

The details of the knowledge and beliefs related to health, healing, childbearing and alcohol will be presented in Chapter V. The analysis includes determination of their orientations: contemporary or traditional, the source from which they were learned, the means of transmission, and the saliency related to the behavior.

CHAPTER V

PRESENTATION OF ANALYSIS OF DATA

PHILOSOPHY OF HEALTH - NATIVE AND NURSING

"Health - it is a way of life. We were taught disciplines for special times of life. Self-discipline is very important in the spiritual, mental, physical, social and emotional environment. There is a circle of life - they (elders) say 'once a man, twice a child'.

There are many teachings and restrictions for us to follow in order for us to be complete. Even from the unborn child, there are teachings for the parents, so they will understand the importance of this sacred child who is our future."

The first step in childhood is that you are taught respect for all nature. You are told that all things created by the Great Spirit are gifts for us all, not for us to possess as our own but to be shared. Our minds and our hearts must believe in the Great Spirit, where all good things come from. The way we treat our child is the way he or she will remember us by. If we teach them love and respect, they will learn to respect the rest of 'life'.

The next step, as an Indian person is coming into adulthood (changing voice or womanhood), the very strict discipline begins. Young people are taught that life is very sacred, and that all life is our relation coming from the same Creator. Purification and preparation for a very young person's future is important. Daily bathing and being careful of what you eat, being alone and meditating are just a few of the rules or disciplines a young person has to follow.

All of this is necessary to develop a new and positive lifestyle, to prepare their body, mind and soul - results were usually a strong heart and a strong will. 'An important part of life is self-respect and respect for our elders'."

This message from a relatively young but wise Native man portrays a core Native philosophy: that of a Circle of Life. It is intimately and completely imbedded in the

holistic perspective of health - a harmony and balance between man and nature. This Coast Salish father and teacher was speaking to other members of the Coast Salish tribe, imploring them to use these important concepts and teachings with their children, as well as with each other, doing their best to make the reserve a good place for their children and elders to live. He challenged them to be an example for all Indian people, "practicing what made our people strong".

An elder's response highlights the seriousness with which this challenge was taken.

> This Indian education is just as important as the academic education. I feel that this should begin to be practiced at home as well as within our communities. We need each other's support. I feel that it is every person's responsibility to become more involved with education. Part of our strength lies in the mystery of our teachings that the non-Indians have yet to discover.

The mystery of the Indian teachings lies within their beliefs and values. The basic requirement of living in harmony with nature gives direction to the lifestyle of individuals, families and communities. This requires attention to the balance of physical, emotional, social and spiritual aspects of health throughout the Circle of Life.

Although couched in terms and exemplified in practices somewhat different from that of non-Native, white nurses, these basic concepts and beliefs are similar to both groups. Kekahbah and Wood (1980) caution the would-be theorist, however, against assuming that a pattern of behavior which fits one society or culture nicely is not

necessarily the best for all human experiences for all times. To practice holistic health care it is imperative that the deliverer of health care be educated in a culturally pluralistic frame.

The discipline of nursing is held by many as being unique among the health professions because of its philosophical orientation to holistic health and health care activities in promoting social, emotional and spiritual, as well as the physical health of individuals, their families and community. A goal of this evolving paradigm, in contrast to the medical model, is to facilitate a harmonious, well-balanced person - environment fit. Thus, it seems particularly appropriate for nurses working with Native peoples to use Native concepts in attempting to decrease the cultural gap between health care provided and needs and concerns of the Native peoples in truly understanding the Native peoples' perspectives and in developing culturally sensitive and appropriate nursing care.

Recently, progress has been made toward advancing a more holistic and humanistic method of delivering health care, but one aspect of the "whole person" which has yet to be fully explored and developed is the cultural aspect.

> An understanding of the part played by culture on the development of the 'total person' is vital to any understanding of the 'total person', whether that 'total' person be a member of the majority culture or one of the minority cultures comprising the culturally pluralistic society in America and in the world community. (Kekahbah and Wood, 1980:1)

The organizing structure for this chapter and Chapter VI is based on an integrated Native and nursing framework. It

includes the constructs of the Circle of Life and the Medicine Wheel in keeping with the holistic, humanistic perspectives. During the course of study, rich and varied data were obtained from observations, participation and interviews. Ten women were interviewed in depth and instruments to measure ethnic identity and self-esteem were administered orally. General questions were asked, with probes as necessary. No rigid interview schedule was followed. All data were analyzed according to the constant comparative method, with detailed content analysis and definition of classifications made.

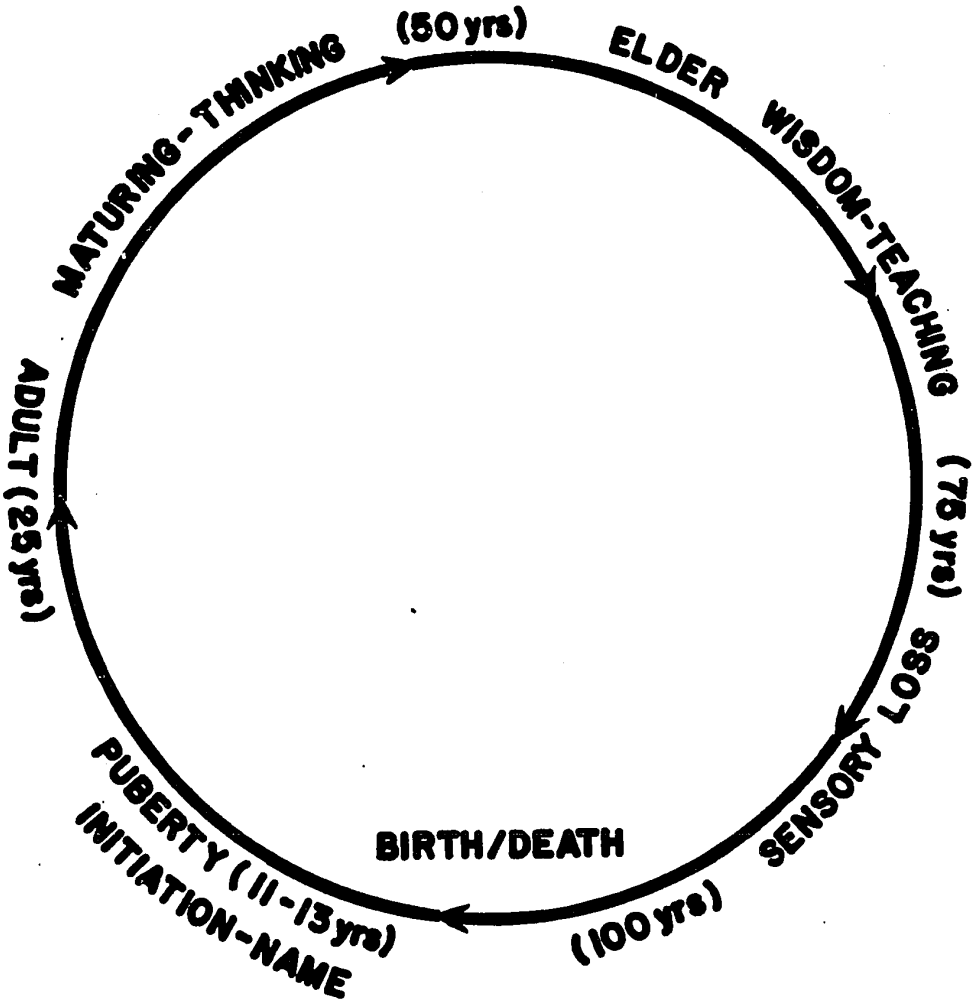
The findings and analysis are presented within the two general constructs which directed the initial data production and then in more definitive categories within the Medicine Wheel construct. The analysis is presented in three forms. The first deals with the transactions that occur between the individual, family and community and their Medicine Wheels; the second is an analysis across Medicine Wheels by direction (i.e. physical, emotional, socio-cultural, and spiritual dimensions); while the third form analyzes the data by Medicine Wheel (i.e. family environment and childbearing woman). Examples cited and data analyzed are composites of all sources.

Circle of Life

The Circle of Life implies a completeness, a wholeness (Figure 5). From conception to death, one experiences distinct and important stages; stages which require close attention to all facets of health and lifestyle for both the individual and family. The family maintains responsibility to see that the disciplines are taught by the

FIGURE 5

Circle of Life



appropriate people - elders, grandparents or other relatives. The mother's brother is preferred if the individual is a boy and and grandparents are not available. For the daughter, other female relatives, such as aunts and older sisters are recognized as alternative teachers. It is the responsibility of the individual to listen to, and learn from, the teachings and to follow disciplines. Support, guidance and constant feedback are given not only by the family, but the community at large. Successful adherence to the disciplines is required in order that the circle not be broken and harmony be maintained.

The importance of the number "four" gives structure to the Circle of Life. There are four stages, some more discrete than others, but each requiring special attention. It is at these times that families prepare themselves and their members in ways appropriate for the promotion and maintenance of holistic health and wellbeing.

Conception to death is considered by the Native peoples to be the Circle of Life. The woman is responsible for taking care of her body and is given guidance and support by family and community members to promote a high level of wellness.

Around the time of puberty preparation of young boys and girls occurs so that they will be ready to take on the new responsibilities for adulthood, another critical stage in the circle. Special ceremonies (eg. naming and initiation) and expectations (eg. spirit questing and changing social behavior) are prevalent and arrangements for them may be the parents' and/or grandparents' responsibilities. In the past, grandparents took a leading role at this time and

frequently the child lived with them for the period of training. Today, the onus is primarily on the parents, as fewer grandparents are still alive or living on the same reserve. The vision quest continues to be important as a beginning step to determining one's place in life and as a means of learning to seek and perceive.

As one moves into adulthood, around the mid-twenties, it is expected that one devote more time to thinking, learning the Native ways and participating in greater depth in community life. Involvement in cultural activities such as the longhouse, winter ceremonials, sports and canoe racing are encouraged by many. It is a time of preparation for teaching one's own children and other Natives and developing the wisdom required of an elder.

Several Native peoples remarked on the "youngness" of the elders these days, a fact that is, in part, the result of tuberculosis and other contagious disease epidemics which occurred among the Native population 50-60 years ago, taking the lives of potential grandparents and elders when they were in their early adulthood. Today's Native population is young in comparison to the white population. This means that on some reserves, people in their 50's and 60's may be considered "elders", not so much because of age, but rather because they are the ones with the most knowledge and wisdom of Native ways of the peoples on that reserve. Becoming an elder is another important arc that contributes to the completeness of the Circle of Life.

A common Native saying "Once a man, twice a child" means that the circle is not complete until one's life situation returns to a state similar to that at birth. As one ages,

one's senses become less acute; there may be loss of memory; and dependence upon family is increased. Whereas one was once a contributing force and power in the community, when one becomes very old, or incapable of active involvement, one moves back into a child-like relationship with the family. It is expected that the family will look after its elderly members, before and after death and only when these obligations have been met has the Circle of Life been completed.

An understanding of the childbearing process thus requires more than an analysis of the prenatal period, or labor, or birth; it requires instead a contextual understanding of the whole Circle of Life, with particular attention paid to the adult woman from conception through postpartum. Childbearing is considered to be a normal and desired, if not, essential to completeness if wholeness is to be achieved.

> The life history of the individual is first and foremost an accomodation to the patterns and standards traditionally handed down in (her) community... By the time (s)he can talk, (s)he is a little creature of (her) culture... There is no social problem more incumbent upon us to understand than this role of custom... until we do... the main complicating facts of human life must remain unintelligible. (Benedict, 1934:3)

The behavior of women and those who assist them in childbearing becomes patterned and regulated into customs and practices, often habitual and traditional in nature. These may, or may not, conflict with planned and rational contemporary and institutional practices and customs that are primarily related to reproductive risk. Contemporary health and nursing services may provide insensitive prenatal care and culturally inappropriate attendants for Native women, as perceived and required by them.

The Medicine Wheel - A Native Perspective

The Medicine Wheel has been described as a way of life of the Native people : a philosophy of life and understanding of the universe (Storm, 1972). It is a way to become whole people : individually and collectively, culturally, socially and environmentally . It is considered to be a mirror in which everything is reflected - an idea, a person, or object (Storm, 1972). "The Medicine Wheel is the Total Universe" (Storm, 1972:5) and yet it is also the individual and the group. It might be conceptualized as a series of concentric circles representing different environments; each reflecting a different perspective. (Figure 6) "The Universe Medicine Wheel" represents and encompasses the potentially different medicine wheels. In this ethnographic study, the Medicine Wheels would include at least tribal (Coast Salish Culture), band (Songhees Community/reserve), family environment and the individual.

Like the Circle of Life each Medicine Wheel is depicted as having four important directions, all equal, all necessary for health, and all contained within the Universal Medicine Wheel. Because the Medicine Wheel represents many things of the Universe, it may be perceived differently as it reflects the feelings of different people who experience it. Thus, the Coast Salish interpretation and teachings of the Medicine Wheel may vary in some respects to their neighbors, the Kwakiutls; and within the Coast Salish tribes, different bands and individuals will have their own interpretations of their Medicine Wheel as a reflection of their life.

The four directions, north, south, east and west, are associated with a seasonal year and a source of power. (Figure 7) One of the child's first teachings is of the four great powers of the Medicine Wheel (Storm, 1972). As one Coast Salish man stated.

> From each direction there is a strength... it is something that I always felt strongly about among my people... there is so much that has to be begun and to be started over... that is why we're looking at the circle.

To the North on the Medicine Wheel is found wisdom. "When the north comes close to us, there is a powerful draw - a magnetism of the north. It is a purity". Winter is the season of the north and is associated with the physical attributes of living. Many teachings, requiring discipline of the body, such as fasting, bathing and physical endurance, are purification rites. They are means of attaining wisdom, the strength of the north.

The East symbolizes each new day.

> Each new morning comes from the east... each one is special... we should thank the Creator for the new day - a new day that can be shared with them and our people - our parents, grandparents and children. The East represents spring, the new season being similar to the new day. It is an opportunity for seeing things in a new light: more clearly.

The power of the East is illumination and is associated with the emotional life of individuals, families and communities.

Figure 6
Universal Medicine Wheel

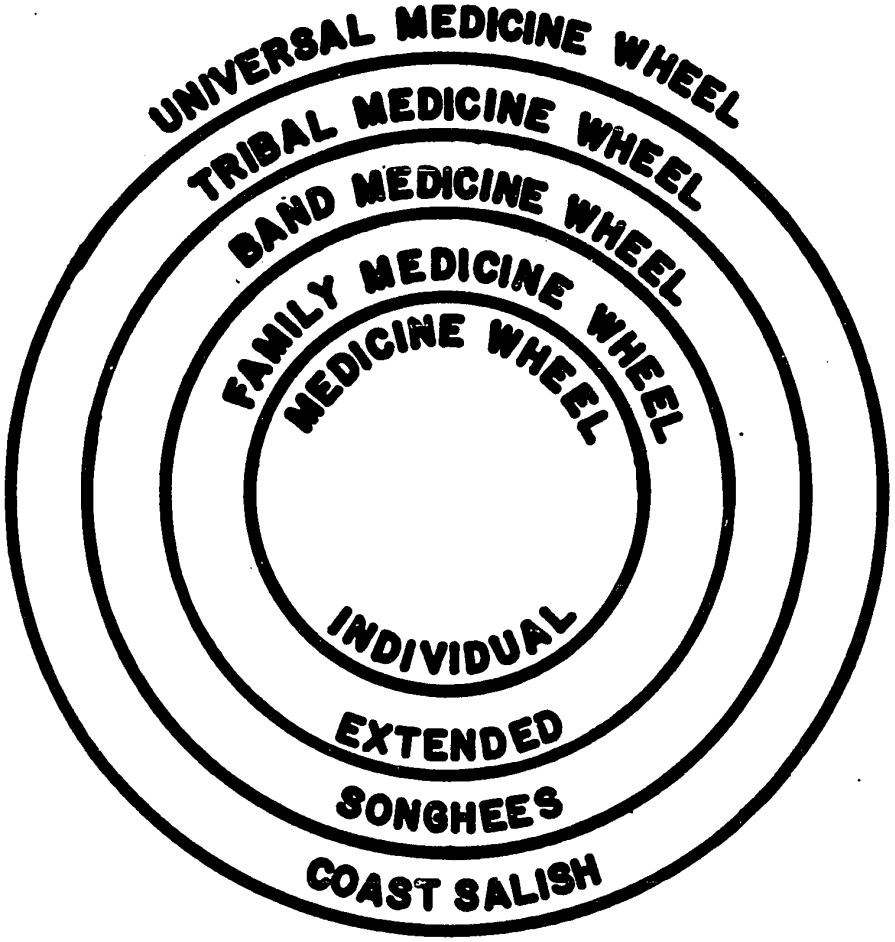
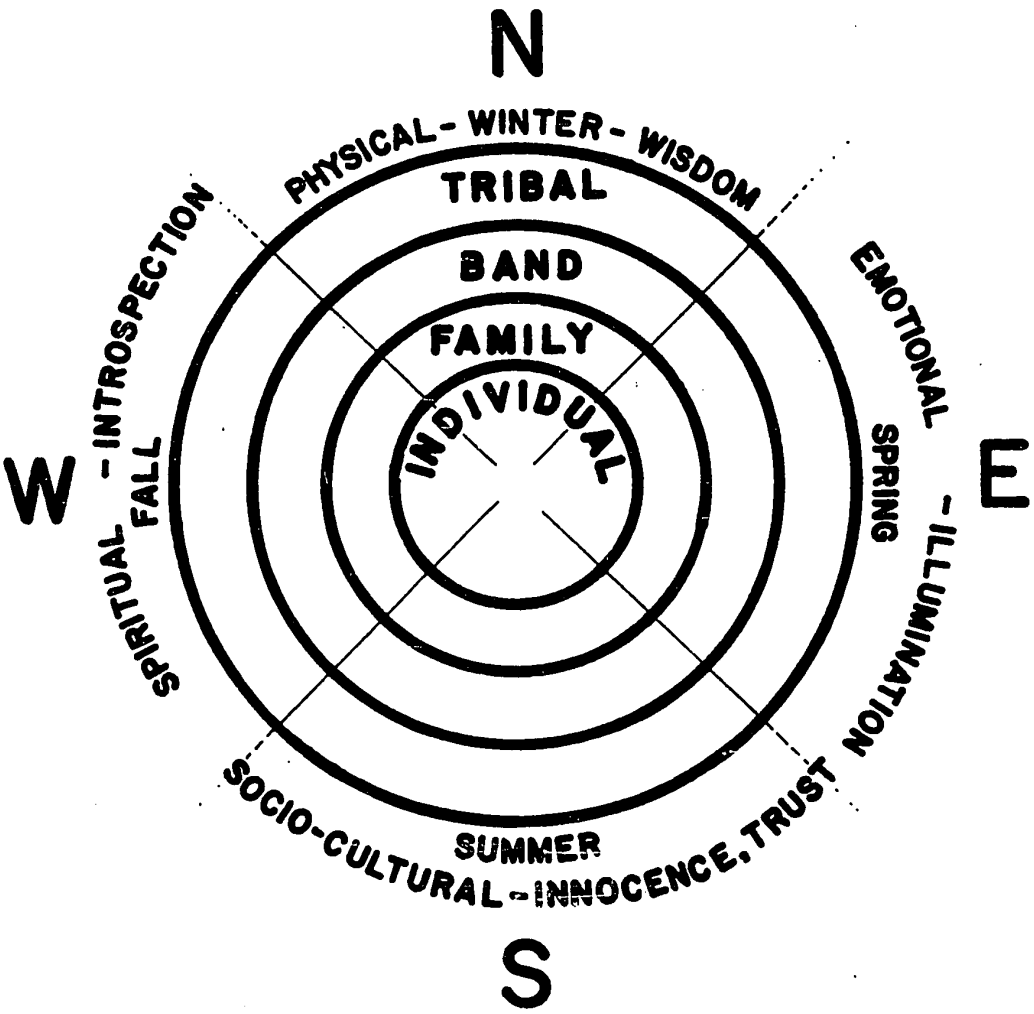


Figure 7
Medicine Wheel: Directions of Understanding



The South is the source of light. It is summer. "Strength comes from trust and innocence, both of which relate to the socio-cultural aspects of life." This strength or power comes from the support and feeling of belongingness one gains in the family, community and tribe, from the involvement and commitment one gives to others.

The West symbolizes the fall season. It represents the spiritual life, a strength or power gained through introspection. "Spirituality is the basis of our culture - spiritual magnitudism - it brightens up your day. Those are the things people believe in - believe it in their hearts." The belief in this spirituality is evidenced in such practices as the dress the individual wears, the oil that the woman puts in her and the way she combs her hair.

> I often tell that to my wife - when you comb your hair - the hair in the brush - you shouldn't just throw it away because there is a lot of social forces - evil forces - could cause internal or family conflicts.

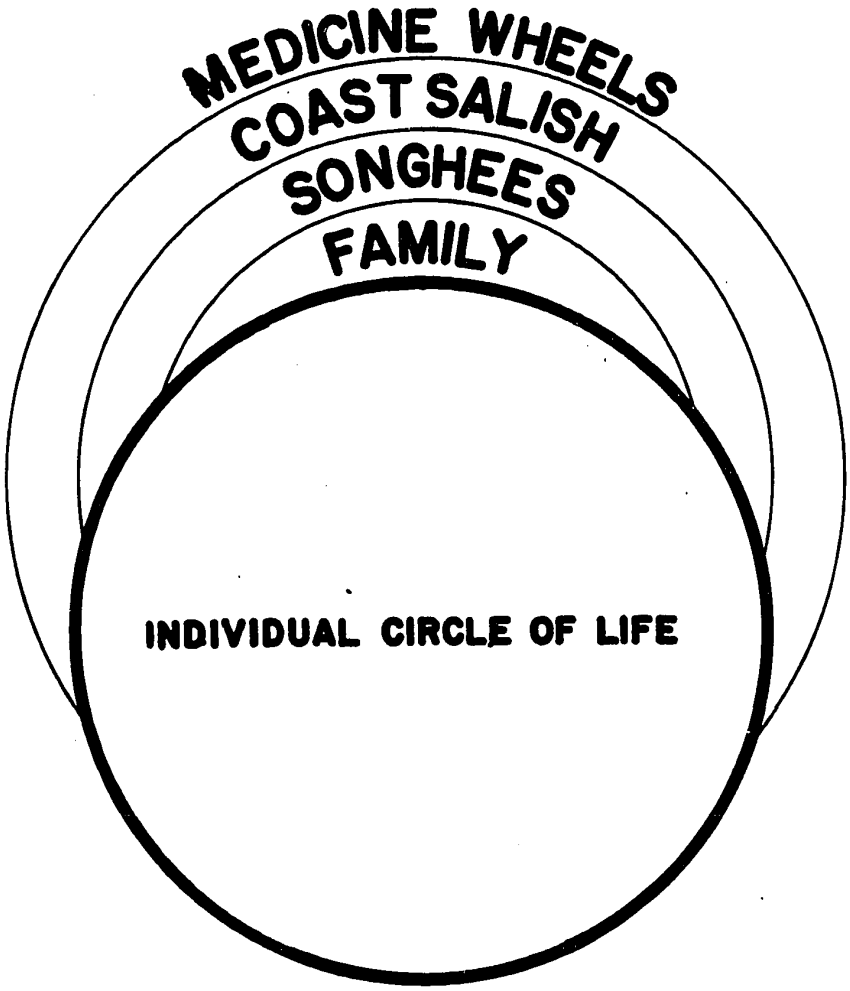
Thus Medicine Wheels incoporate four cycles - four directions. "Those are the things our parents and grandparents taught as the importance of the complete cycle." Not only is it important to the Native peoples for the circle to be complete, but it is necessary to experience and perceive each of these directions throughout life. Any person who perceives from only one of the directions will remain a partial person, maybe very wise, but cold, without feeling. It is believed that there are many people who have two or three of the strengths, but they are still not considered whole. One aspect is still missing. The ultimate goal of many Native peoples is to grow by seeking understanding in each of the four ways and putting this

understanding into practice in daily living. "Only in this way, can we become full, capable of Balance and Decision in what we do" (Storm 1972:7).

Practicing the Medicine Wheel philosophy should be an everyday occurrence regardless of the point in which one is currently living in the Circle of Life. Coast Salish peoples stress the importance of preparation for normal transitions throughout the Circle of Life by teaching disciplines and providing learning opportunities appropriate to the person. In doing so, the various Medicine Wheels impact throughout the circle of one's life. Figure 8 illustrates how closely these two concepts are associated. Wellness at any point in the Circle of Life is experienced when there is a balance between the individual and her environment, i.e. a harmony among, and completeness of, the Medicine Wheels.

Although childbearing is considered one of those special times in the Circle of Life, and one that is generally desired if not expected, it is treated as a normal process. To ensure a balance or harmony especially during the first pregnancy, certain disciplines in each of the four directions of the Medicine Wheel were reported as having been taught. The target of the teaching was primarily the pregnant woman, and to a lesser extent her partner; while the rationale for teachings was primarily focussed on fetal outcome and to a lesser extent on maternal health. It is of interest to note that it was primarily the male informants who described the conceptualization of the Medicine Wheel and Circle of Life and took the time to articulate the more global holistic perspective. They dwelt very little on the specific beliefs or

Figure 8
The Circle of Life Within Medicine
Wheels



practices, and when questioned about these, directed the investigator to female relatives. Their reasons for not discussing specifics were two-fold. On the one hand, as one male elder said "you should be talking to my wife; she looks after those things": knowledge of the Circle of Life during childbearing and the relevant Medicine Wheel teachings were the domain of women. On the other hand, several male informants declined to describe specific beliefs or practices at anytime during the Circle of Life because these were sacred or spiritual, would not likely be understood by a non-Native, or were the property of the family, to be passed on only to family members.

The women informants and subjects tended to recount specific beliefs and practices, frequently stating how they had tried to recall the teachings of their grandmothers or mothers in preparation for the interview. This was then reflected in a recounting of disciplines in each of the four directions of the Medicine Wheel, although the women themselves never referred to the directions, per se. When women spoke in generalities, they most frequently referred to first pregnancies and the importance of teachings, disciplines and monitoring by grandmothers or mothers, especially mother-in-laws. "I was watched like a hawk by my grandmother during my first pregnancy - especially what I ate and how I behaved" said one young mother of three, expecting her fourth. Another woman, in her second pregnancy stated "My mother-in-law taught me many things in my first pregnancy - especially to be careful, don't over do it, don't lift heavy things." Pregnancy was considered a training period, a special time for women to prepare properly for the role. Like puberty and menstruation, childbearing was, and to a large degree still is,

considered to be the domain of women. Only within the past few years, when most births have taken place in hospitals, and partners have been allowed or encouraged to attend labor and birth, have Native males been privy to this aspect of women's lives. One of the female elders described her first pregnancy "when I was living with my man, and in the family way, my grandmother really watched me - she wanted the first pregnancy to be done the right way. After that you are supposed to know what to do."

Thus, a philosophical approach towards the life cycle and wellness was predominantly a characteristic of the Native males, whereas the females' approach focussed primarily on the pragmatics, especially during the childbearing period.

The Medicine Wheel - A Nursing Perspective

From a culturological nursing perspective the Medicine Wheel philosophy and orientation to living and growing in wellness is particularly appropriate to the present study of traditional and contemporary childbearing practices. Leininger (1978) uses the term "culturological" as a descriptive adjective to refer to culture phenomena in their broadest sense. A culturological nursing perspective then is a holistc view of an individual's total cultural context and environment.

Culture provides the design for the childbearing women's experience. Her immediate environment, stipulated by cultural values and beliefs, world view and context for practices is provided by her family. Her health-related behaviors are based to a large extent on the family's values, beliefs and teachings regarding her physical, emotional, socio-cultural and spiritual health. Other

factors thought to influence her behaviors are the teachings of society that extends beyond the Native community.

The fit before the childbearing woman and her more extensive environment is frequently mediated by the family. On several occasions during the study family members mediated on behalf of the informant to control participation in the study. Although in two cases, the women had given permission to be interviewed to both the Community Health Representative and investigator, the actual session was terminated, in one instance by the husband and another by the woman's father. In another situation, the woman interviewed had spoken with great admiration of her mother's knowledge and wisdom, but when requested to seek her participation in the study, made many excuses for not approaching her mother.

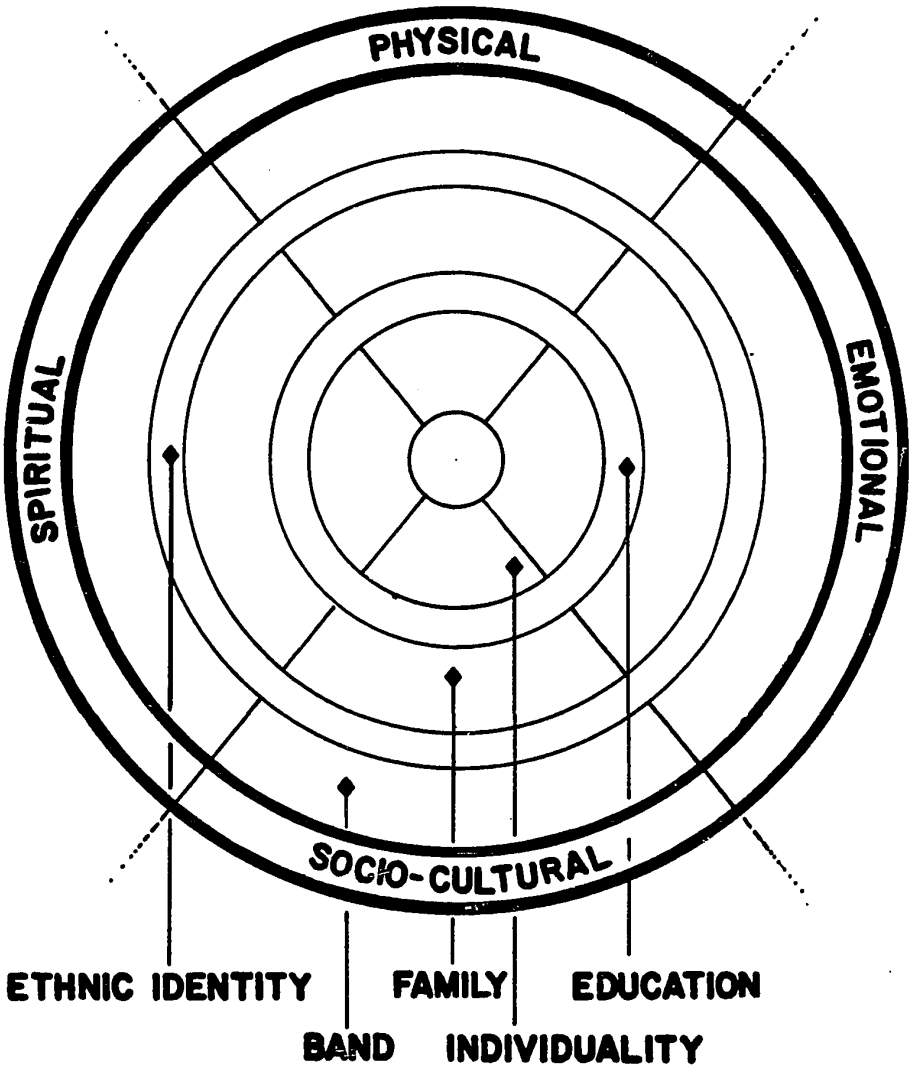
Not only does the family environment act as a mediating force between cultures, it was found to be an integrative one as well. Those women attending prenatal classes, and they were few indeed, generally did so with the encouragement and support of their mothers, who accompanied their pregnant daughters to the non-Native oriented classes held in the city. Without this integrating mediator, pregnant women found it difficult, and at times meaningless to attend. Several woman reported that they had convinced their partners to attend classes with them, but after the first one, they refused to go back. The men did not see the relevance of the classes and thought they were boring. Most frequently, the women did not continue either, or if they did it was sporadic and infrequent.

The family environment may also be described as the mode for expressing and learning ethnic identity appropriate to the tribal affiliation and as the mechanism for education. If balance and completeness of the Medicine Wheels is to be attained, two culturological factors were found to contribute significantly to the process. These were the concepts of ethnic identity and education. (Figure 9) Ethnic identity provided for and encouraged the woman's transactions with her community through her family, while education was critical to the family-individual transactions, the aim of which was to transmit Native values and beliefs. The family environment provided varying degrees of support to put these into practice. At the centre of all Medicine Wheels and the core of the individual woman was her self concept.

Socio-cultural adaptation involves the transmission of cultural solutions and traditions, mobilization of social and family networks and support and participation in community life. A transactional process was found to occur between the woman and her environment as one adapted to the other. The family was frequently a important mediating force for this transactional process to result in a healthy person-environment fit. On the one hand, the family reflected to its members the Native identity of the band and/or tribe, and on the other hand put family members in situations which contributed to their enculturation. Through ethnic identity, social-cultural adaptation was enhanced, if not entrenched.

Ethnic identity, being Native and all that meant, was very often stated as the reason for doing things, such as taking time off work in a non-Native job, going ahead with a

Figure 9
Medicine Wheel and Coast Salish Childbearing
Nursing Concepts



Native project even though the intended outcome was unlikely to be reached, and being without material goods or financial resources. Deciding upon whether to carry out certain practices and activities of daily living was almost invariably related to one's feeling of being Native, or Coast Salish. Thus, ethnic identity may be conceptualized as an important dimension linking the individual's Medicine Wheel to the larger one of the community, primarily through the mediating family Medicine Wheel.

The link between the individual woman's Medicine Wheel, or way of life, and that of her family's occurs via another transactional process, that of education. Teaching and learning on the parts of both adults and children are conceptualized as education. Education includes not only conscious teaching of any sort, whether of speech, manners, morals or skills, but also the processes of socialization, and enculturation. Socialization occurs in all societies as individuals learn to participate as effective members in social life: while individuals learn a culture with its uniqueness and particularity by the process of enculturation (Mead, 1974). Education is considered to be a deliberate effort - an effort that is the focus of aware attention. However, experiences at the margins of consciousness or at the level of peripheral awareness, remain part of the educational process as well. Much of the activity within the Native family is of a repetitive, moment-to-moment nature. Repetition through story-telling, role-modelling and monitoring expected disciplines was recounted by many as intentional on the part of the adult teacher, but was not necessarily taught in a formal manner.

In this rapidly changing world adults and children are both teachers and learners, with the child often teaching the

parents or grandparents about the community outside the reserve, and the adults teaching specific values, beliefs and practices to help the member meet the social and cultural expectations of the family and band, and to promote their overall health throughout the Circle of Life. The presence of grandparents inparticular, and parents in general, was noted to be particularly salient to the learning of Native ways. Parental and grandparental transmission of tradition has been a historical aspect of learning for Native peoples. A variety of educational encounters between individuals and their familial environments have been viewed as critical to the transactional process. Frequent responses to questions that the informant could not, or preferred not, to answer were "I don't know that. I had no grandparents around," or "I can't tell you about that. I was sent to residential school. When I came home for holidays my mother was too busy." Thus, education - teaching and learning - has been conceptualized through field experience as the necessary link between the individual's family's ways of life, i.e. their Medicine Wheels.

Ethnic Identity - The Findings

Ethnic identity refers to the way group or members of a group categorize themselves in reference to others and attempts to associate or disassociate with persons whose culture is similar. The degree of ethnic identity varies along three dimensions: cultural content, historical experience, and group image (Spicer, 1972).

Because the group's ethnic identity is indeed more than the sum of its members' ethnicity, ethnic identity was measured

at two levels for the purposes of this study. At the group level ethnic identity was determined by content analysis of observations made during visits to the reserve, involvement in a Native health committee, attendance at summer canoe races and participation in Potlatches. An individual's ethnic identity was measured quantitatively by the "Ethnic Identity Scale" (EIS) and qualitatively through content analysis of interviews and observations.

Content analysis of the observations and interviews identified subcategories within the major categories: cultural content, historical experience, and group image. Cultural content refers to the sensitivity one has to the behavioral differences and uniqueness of one's own people, reflective of their standards, values, beliefs and practices. This included subcategories of knowledge of, or involvement with, Native language, arts and crafts, as well as specific Native or family customs and practices.

Historical experience refers to the shared history one has with the band and family and the involvement with Native rights, laws and expectations. Specifically, it includes subcategories of family background, schooling and learning about one's heritage. The category of group image incorporates the moral valuation of the group in relation to other groups and is thus reflected in subcategories of reserve life and off-reserve activities, i.e. relationships with Native and non-Native peoples.

The second means of determining Native identity was through the administration of the EIS: an adaptation of one developed by Okano in his study of Japanese Americans (Okano, 1977) (Appendix C). The scale was analyzed

according to the major categories identified in the content analysis, as well as subscales based on values and concepts believed to be of central importance to the Native peoples. (Appendix E). Items 4, 6, 10, 11 and 14 indicated the cultural content orientation; items 2, 3, 8, 9 and 15 reflect the historical experience of being Native; while items 1, 5, 7, 12 and 13 relate to the group image.

The subscales based on Native values were Social Relationships, Learning, Caring for Others and Traditions. The importance of "belonging", developing or maintaining a cohesiveness among the family or reserve defined the Social Relationship subscale; Items 5, 6, 7, 11, 13 and 15 were included. Learning was highly valued among Native peoples and is consistent with their concepts of the Circle of Life and Medicine Wheel. One is never complete during one's life; there is something to learn everyday, especially from the elders, and it is an individual responsibility to learn and take advantage of the opportunities.This orientation is reflected in items 2, 9 and 10. The Native value of being part of a larger whole and contributing to community living and family life is defined by the subscale of Caring for Others. Items 1, 3 and 12 are included in this subscale. Items 4, 8 and 14 make up the fourth subscale, Tradition. They address the concepts of customs, heritage and uniqueness of being Native.

Cultural Content

Interviews - Observations

It was assumed that Native standards, values and beliefs would be reflected in their reports of traditional practices and investigator observations of behavior. Another assumption was that the behavior and practices oriented to the Native culture were indicative of a sensitivity to the differentness and uniqueness of their ways. Much of this was observed at canoe races, pow-wows, health committee meetings and a potlatch. The privilege of observing these Native events and talking with participants and observers was indeed enriching.

Native languages and customs have not died out; in fact the Native peoples appear to be making a determined effort to assure their viability. Learning the Native language is seen as one of the most important means of maintaining this viability, important right from the time conception. As one person said "when you speak the Native tongue, you speak it from the heart, with feeling. Meanings can't be said the same in English."

It is feared that with many of the elders and grandparents gone, the knowledge of the language will decline and result in a loss of culture. Many of the women in the childbearing age commented on their need to learn their language and regretted having passed up opportunities to do so during their younger life. Even those having attended residential

school identified subsequent opportunities that had offered themselves for learning the language. One of the incentives to learn the Native language seems to be requirements of the childbearing and childrearing periods. The realization that there is much they should be teaching their children but cannot without more knowledge of their culture, brings parentsface-to-face with demands of knowing their language. Some of the women, including those past the childbearing age, wanted to learn more of the language so they could understand all that goes on in the Longhouse. Many feel that it is a sign of disrespect not to be able to understand someone, especially elders, and respond appropriately when spoken to in their Native tongue. To understand Native needs and way of life many feel that you must know the Native language, even the specific dialect, as these differ significantly between bands and even reserves. "The prayers were beautiful when said in Indian-some of the hymns and songs are so beautiful - almost make you cry." In a number of instances when a concept or quality was being described, there was no translation for the Native word. An example is found in the word "sinuit" - a quality or characteristic related to those who have an innate inner spirit: a power that can be strengthened through disciplines, quests and learning - a quality of being wise and helping others.

Identifying the individual's potential and unique "sinuit" early in life is believed possible and desirable so that appropriate experiences and teaching can be planned throughout the early part of the Circle of Life to enhance the power. Experiences for both sexes include: purification activities such as bathing in streams or rivers and fasting; vision quests which demand isolation, meditation

and survival skills in the woods; tutorship by an elder; initiation into the Longhouse involving teachings and disciplines; or involvement in the Shaker Church, learning to be a healer. A mother described how she and her husband had "hired" a wise and respected Coast Salish male to take charge of their son's quest for his spirit when he was "changing his voice" last year. This teacher, a relative of the mother, was also respected for his wisdom and knowledge of the Native ways, as well as for his own spirit power. His responsibilties for the teaching and guidance of the young boy extended over many months during which he would take the boy out into the woods where they would bathe, talk and meditate. The teacher described this experience as a renewal for himself, as he had to fast and observe a number of disciplines so that he could teach the truth. He taught about the Medicine Wheel - the Native way of living and the requirements demanded at particular times during the Circle of Life.

Other purification rites are still practiced and being taught, but some say to a lesser extent than in the previous generation. However, the practice is prevalent during the season of Winter Ceremonials when initiation to, and "work" in, the Longhouse takes place. During the period of the study three of the childbearing aged women were practicing members of the Longhouse, having been initiated several years before. Two of them had been "grabbed" and put in by their families. They spoke of the fear they had when this happened, because although they knew that the disciplines were strict, the specific nature of the requirements and activities are not talked about outside the Longhouse. One of the non-childbearing women, a respected elder, was "working" in the Longhouse and

spending most of her evenings there.

The season used to extend from February to April, but now begins as early as November. The Longhouse is described as a source of renewal and rebirth, a place of support and relaxation, and a means of learning and increasing one's strength. It is associated with memorials to the dead, naming and initiation. Today initiation occurs in one of two ways; the individual, man or women usually over the age of 17, volunteers to enter and is sponsored by the family, or the individual is "grabbed" by a family member or relative and put into the Longhouse, frequently for the purpose of changing some socially undesirable behavior such as drinking or delinquency. Being "grabbed" may be anticipated or come as quite a surprise to the individual. It is a most appropriate term, as the individual is, for all intents and purposes, grabbed and forced into the Longhouse. The initiation period extends over a number of months, sometimes as long as six or seven. In the beginning, all the initiate's time is spent in the Longhouse under the tutorship of the sponsors and/or other selected teachers. These people do "the work of the Longhouse" i.e. teach about the Native ways, enforce the disciplines required, assist the individual gain his or her song and dance and assume responsibility for developing the spiritual health of the initiate. After the first month or so, the initiate is allowed out during the day if he or she has employment off the reserve in a non-Native setting. Return in the evening is required to receive the sponsors' "work". The initiates must adhere to the strict physical, dietary and emotional requirements. Prior to leaving the Longhouse at the end of initiation, they may spend several nights a week out in their own home to help with the difficult tran-

sition to the "outside". A "taking-off" ceremony occurs when the initiation is over. However, the following year the new member returns to the Longhouse for a short, intensive period, has the teachings reinforced and gets a dance costume. The individual is then known as a "Dancer" and must wear her/his dance costume at least once a year, i.e. must participate actively in the Longhouse at least once a year.

During the season of the Winter Ceremonials, those who are involved in the Longhouse should neither smoke nor drink. To the chargrin of some members, this rule has been relaxed to the extent that it really means now that no alcohol or cigarettes are allowed into the Longhouse, but people are admitted, even if they have been drinking just prior to coming They might be encouraged to stay out if they are inebriated, but rarely would they be refused admittance. Nonetheless, adherence to the teachings of the Longhouse plays an important part in the culture of the Coast Salish peoples, and those living on the Songhees reserve, even though they have to attend a Longhouse on a neighboring reserve. Although not all Native peoples agree with the Longhouse, they are quick to state that they respect those who are members and teach their children to share this respect as well. Several people from the same extended family told of their family's traditional orientation to the Longhouse. They did not agree with it and did not want any of their members to be involved. Instead they belonged to a "Masked Dance". It seems that membership in both the Longhouse and a Masked Dance society are not compatible.

However, membership in the Shaker Church may occur in conjunction with membership in the Longhouse. Involvement

with the Longhouse leaves little time for activities in the Shaker Church in the winter, so as one person described the situation, "some people are in the Church in the summer and the Longhouse in the winter - they just change from one to the other - they are different, but both Native". Many homes had an altar, typical of the Shaker religion, with bells and candles displayed, along with a religious statute or tapestry. This Native religion is currently practiced by many and the healing qualities attested to by young and old. A gentleman described how his wife's progressively deteriorating eyesight was restored with a series of four "shakes". Previous medical attention had apparently been of little help. Many spiritual values and beliefs are reflected in the work of the Shaker Church, not the least of which is a faith in the power or "sinuit" of certain individuals and the presence of a Creator.

Native values and beliefs were also expressed by virture of involvement with sports, particularly the canoe races in the summer season. Training for "pulling" begins in May, with races taking place up and down the coast of Vancouver Island during June, July and August. As with the Longhouse, there are a number of restrictions and requirements for the participants. Both men and women train three to four times a week for "pulling"; they are not to smoke or drink during this time; and men are "not to be with their women". Recent losses that a team had in the past season were suggested to be due to one, or a combination, of four factors: the team was overtraining and therefore tired at the time; some of the team members had been drinking; "someone had cheated and been with his woman"; or "there is some force".

On the weekends, families migrate to the beach where the canoe races take place on Saturday and Sunday. They stay with friends and relatives or camp in their vehicles. Besides canoe racing, there are bone games and the inevitable gambling or poker table. Both men and women engaged in all these activities, from the adolescent to the elder. Bone games were accompanied with chanting by a watchful crowd to the persistent beat of drums. There was usually a Native run food stand, with bannock and salmon sold in great quantities, along with coffee and soft drinks. Occasionally there would be a rush and line-up - a fresh lot of crabs had just arrived. What better way to reflect on all the activities and people, than sitting on a log in the sunshine, surrounded with water and people sounds, indulging in the fine art of eating uncracked crab with one's fingers?

The Coast Salish peoples also place great value on respect, conservation and non-material wealth. It is believed that these teachings began from conception. One is taught to respect others, even if one does not agree with them. If there are two differing opinions, "you have to respect both and plan accordingly". Actions are not taken in haste, lest disrespect be shown because of ignorance. Therefore quick decisions are not likely to be made in one's personal, family or community life. In particular one is taught to respect the elders, not only for their age, but their wisdom, experience and "sinuit".

A philosphy of conservation, according to the teachings, demands that nothing is wasted. This includes parts of fish, animals and food, as well as trees and nature. From first impressions of the physical environment of the

reserve, it is difficult to accept that this is a contemporary value. Old vehicles and toys, remnants of fish lines and crab traps, boxes and bottles are in plain view. However, when one observes the activities surrounding the more traditional life and food preparation, values are evident. "The ways of the earth are understood" was the way one elder described the situation. What she seemed to mean was that an understanding of the balance of nature and the importance of the land, as a basis of culture, directed one's actions in using the resources of nature and the land to maintain respect and harmony. Thus, the natural resources of the land and the people are of importance, not the material goods purchased with money. Several people spoke of having "family wealth" or "wealthy in our own way". They were quick to state that this was not a material wealth. It was a wealth based on tradition. The tradition of sharing exemplifies to this day the relatively inconsequential value of material possessions. Rather what is believed and practiced is: "you know when you give things away that if there was a time you needed something you would get it."

Another factor related to cultural content is the extent of involvement in Native arts and crafts. Both men and women make and sell Native work through their own private network, as well as non-Native and Native retail stores. The men tend to be primarily involved with carvings and painting or print making; while the women continue the traditional crafts of knitting and beading. The art of basket weaving appears to have been lost among this group of Coast Salish. In the homes, Native artwork finds its place next to numerous family photographs of past and present generations. When visiting the homes, the woman

took great pride in describing the qualities of the person in the photograph and how she was related to the person. This was a way of expressing respect in past and present generation's and was a source of pride for both childbearing and non-childbearing women. The childbearing women tended to focus more on the present generation and their children; whereas the non-childbearing women, especially the older ones, focused more on the past generation.

Band offices and Longhouses are painted in Native motifs with signs in the Native language and totem poles in the vicinity. A Native public school serving the South Vancouver Island area, with its own Board of Trustees, is building a curriculum based on Native values and practices. Children learn their own language, history and customs, as well as the basic required subjects. Recently, there has been interest shown for adult education in Native ways and a small group started to collect some of the teachings, but has never finished the task. An outcome was envisaged similar to "Teachings of our Elders" compiled for the Cowichan Band, a Coast Salish band up the coast of Vancouver Island.

Although there is a fear among the Coast Salish peoples that their teachings will die out with the few elders that remain, it is clear that efforts are being made to reduce the likelihood of this happening. As in most societies, a few are taking the major responsibility to see that the values, beliefs and practices are preserved for the whole community. Others are, in their own quiet way, continuing the customs of the Coast Salish. Both the childbearing and non-childbearing women were participating through active involvement or observation, or had family members in the

Longhouse, Shaker Church, canoe races, sports and group ceremonies (e.g. birthdays, weddings and funerals).

A description of a ceremony held during the study period for deceased family members typifies the peoples' involvement. The brothers had decided to have a ceremony honoring their deceased grandparents, mother and sister. An invitation had been issued to all reserves on the south of the Island the previous winter in the Longhouse. The occasion is described as one of "like paying last dues". The family is responsible for doing the "work" of dancing and singing the family traditions. Preparation for this takes many months of practice to make sure that it is done right, i.e. is authentic. During the ceremony the songs and dances were taped so they could be preserved for the family. The "work" is done early in the ceremony, followed by drumming, dancing and singing by guests according to their band or family, and distributing gifts to witnesses and guests. Donations of food from members of the family's reserve and extended family provided a memorable feast.

Ethnic Identity Scale

Based on findings from the Ethnic Identity Scale (EIS) the importance placed on the cultural component was indeed varied. (Table 2) In general, childbearing women placed less emphasis on this component, except for the importance of Native customs (Item 4) than non-childbearing women. However, there was great diversity of opinions among the childbearing women. Of least importance to the childbearing women was the need to know the language (Item 10), which contrasts sharply with the older non-childbearing women who not only considered this the most important

TABLE 2

Ranked Mean Scores and Variances of Ethnic Identity Scale Items

Childbearing and Non-childbearing Womaen (n=10)

Scale Item	Rank Order[1]	Childbearing Women (n=6) $\bar{X}$	σ	Non-Childbearing Women (n=4) $\bar{X}$	σ
1.	Responsibility re: prejudice #	8	6	8	6
2.	Learning heritage+	6	12	2	14
3.	Helping each other+	5	7	5	9
4.	Importance-Native Customs*	2	1	6	8
5.	Vote Native#	11	5	7	7
6.	Comfortable with Natives*	9	3	15	10
7.	Marriage - Native#	10	2	4	3
8.	Indian-Canadian feeling+	4	11	12	1
9.	Responsibility re: ancestry+	3	13	10	12
10.	Learning language*	14	9	1	15
11.	Native health Workers*	13	10	14	11
12.	Reserve living#	1	14	3	13
13.	Native friends#	15	15	13	4
14.	Native Spirituality*	12	4	9	2
15.	Band attachment+	7	8	11	5

[1] rank ordered from high to low for mean scores and variances

#Cultural Component of Ethnic Identity

*#Historical Experience Component of Ethnic Identity

*Group Image Component of Ethnic Identity

element in the cultural component, but the most important to Native identity in general, and they were in total agreement. One older mother stated that her uncle was starting to share the Native heritage with her and she had been attending the Longhouse for the past couple of years.

> I try to get my kids interested, but they don't like it - they don't understand the Indian language. I feel badly - now they don't know the Indian ways and the Indian food .

The two groups of women were more similar in their orientation to preferring a Native health care worker (Item 11) and social relationships (Item 6). These they considered to be of least importance to maintaining a Native identity. There was the obvious implication of availability of Native health care workers, trained at a level required for total health care. As well, many stated that it would not matter as long as the health care worker was sensitive to the ways of the Native peoples, was available, not prejudiced and the woman and health care worker were compatible. In fact, in several instances, it was pointed out by the women that it might not be advisable to have only Native health care workers on the reserve because of their bias to providing or restricting certain treatments they considered appropriate and also because one meets them socially.

Historical Experience

Interviews - Observations

One of the more important means of sharing family history is through the tradition of naming. An Indian name given to an individual at one or more times in her/his cycle of life. Receiving one's name is likened to a

"rebirth - it is a gift from people that went beyond - it is a gift to be treasured". The name to be given is determined by the family and is usually a name handed down through generations. If required the male name can be feminized by changing the ending. Many responsibilities go along with naming. One is expected to follow in the steps of the person who previously had the name, and to live-up to the standards of that person. The family can "strip" the name from the person if the standards are not met. This was described as an extremely shameful occurrence and one to be avoided assiduously.

"Witnessing" is critical to the validation of historical experiences. Individuals attending naming ceremonies, Longhouse initiations, memorials for the dead, etc. are requested to act as witnesses. They are paid by the family for attending the entire event and participating in the ceremony. Witnesses are responsible for recalling qualities of the person with the name as well as the history of the name, observing initiation practices and helping remember the newly acquired song and/or dance, and recounting the history of the deceased. Besides this contribution to the present event, witnesses carry the responsiblity of validating in the future what has just been done. Thus, witnesses are carefully chosen by the family.

The Coast Salish peoples have traditionally taken children from other families into their care accepting and treating them as they do their own children. They do not usually legally adopt, but accept another member into their midst when there is a need. "We look after our own - there's always room for one more". Not always is this informal

arrangement a happy one, however. Several men and women described how difficult it was for them when the child's mother came back to reclaim her child. The void created in the family with the loss of a loved one was at times compounded with the fear that the mother would still not be able to adequately care for her child.

Both childbearing and non-childbearing women recounted examples of foster care. Taking children into their homes for periods of months or years was generally received as positive experiences for themselves and their family. It was seen as another opportunity to teach the Native ways and help the individual "think like a Native, not just look like one." The less positive experiences occurred either with the taking in of adolescents, who were impervious to disciplines required by the family, or the loss of young children back to questionable mothering capabilities.

Several of the women had themselves been fostered for part of their life. The situations where adoption or fostering continued into adulthood occurred were characterized by the biological mother recognizing very early after conception or birth that she could not look after her child appropriately, requesting a relative to accept the child and the fostering parents being unable to conceive or have more children. The individual usually knows the biological mother and, depending upon the relationship, may refer to her as "aunt". In several instances when the child was fostered until adulthood, the biological mother had also taken up residence with the fostering family. Thus both the child and her mother gained in learning about and practicing the Native way of life. The Native families of south Vancouver Island are presently making a determined

effort to find their children who were put into non-Native foster homes in the past, reclaim them and teach them the Native ways.

"The decay of our culture has occurred for many reasons; the hurting must stop". Some Coast Salish peoples are trying to revive the pride in being Native encouraging "young people who have drifted away from the words of our grandfather" to develop strength, health and common sense and to learn from the past generations. Even though deprived of the rights to have potlatches, speak the Native language and practice their own religion there has been cultural survival. Some consider this survival an indication of rebirth.

Continuation of masked dances, pow-wows and funeral observances attest to a cultural survival. The masked dance and song continue to be passed through families via the eldest son, who must adhere to strict rules with respect to the dancing and singing. Strengthening the inner spirit through initiation in the Longhouse or vision quest, individuals' acquire their own song and dance. Other family members or witnesses learn these, not to pass them on through the generations, but rather that they might help the individual recall them should that be necessary or to be able to perform the rituals to honor the individual after death.

The Historical Experience of Native identity continues with calling first cousins brothers and sisters and never using their English name in Native ceremonies. If they do not have an Indian name they are referred to as "my brother" or "my sister". People with special power or "sinuit" may be

elected by elders to be a speaker. This is an honour and requires many years to develop one's style. A son referred to his father's remarkable ability as a speaker: "he wears it well". People such as this speaker play major roles in community events, such as funerals. All members of the reserve and many from neighbouring bands attend. Work on the reserve is stopped and the Band Office is closed for such important occasions. It is a time to remember the past in the present and use the present to prepare for the future.

Ethnic Identity Scale

For the childbearing women, Historical Experience was rated as a whole, as being the most important component to their own Native identity (Items 9, 8, 3, 2 and 5), and they were in general agreement with each other (Table 2). Many of the childbearing women remarked on the need to learn the Native ways now that they were having a family themselves. They felt their present knowledge of their culture was inadequate for their parenting role and teaching their children the Native ways and what it means to be a proud Indian.

However, for the older women, some aspects of Historical Experience were more important than others. Learning about one's heritage (Item 2) and helping each other (Item 3) were rated as being important by most women in this group. Variability was high for the older women regarding identification with a Native or Canadian feeling, (Item 8) and for both groups of women, there was considerable diversity in Band attachment (Item 15). The variances seem to be related to accounts of individual experiences,

especially in relation to the Band council, rather than to a more wholistic approach encompassing one's total life. Although there is no statisically significant difference between childbearing and non-childbearing women on the Historical Experience subscale (Table 3), empirical differences are significant. The non-childbearing women place less emphasis on thinking of oneself as primarily Native, dwelling on the responsibilities of being Native and having a strong attachment to a Band than do the childbearing women; who place more emphasis on learning one's heritage. For the non-childbearing women the historical experience is related more to the family while for the childbearing women, the broader context of being Native is salient.

Group Image

Interviews and Observations

Not only was discrimination observed and recounted by the Native peoples, it was experienced by the researcher when she was with them. Native-non-Native relationships are characterized by discrimination in both directions. Some non-Natives refused to serve Natives and others in the past have denied Natives rights to their own culture. On the other hand, Natives tend to view non-Native perspectives as "the outside world - outside our circle" and are skeptical of those wishing to learn more about the Native ways. Even though the Band Council had given the researcher permission to be on the reserve and talk to the members, several refused to participate until they checked with the Chief and Council. Yet others were eager to share an understanding with the non-Natives.

TABLE 3

Coast Salish (Songhees) Ethnic Identity Comparison of Mean Scores - Components Childbearing and Non-childbearing Women

		Total (Score=60)		Cultural Component (Score=20)		Historical Component (Score=20)		Group Image Component (Score=20)	
Women	N	$\bar{X}$	σ	$\bar{X}$	σ	$\bar{X}$	σ	$\bar{X}$	σ
Childbearing	6	45.66	4.633	14.5	1.048	17.5	2.429	13.66	2.2509
Non-Childbearing	4	45.75	4.1932	14.5	1.290	15	1.414	16.25	2.217
t value	10	-0.0311		0		1.8386		- 1.7933	

Native and non-Native marriages occur, but they are discouraged. Native parents may actually forbid the legal marriage, prohibit courtship with non-Natives or request the non-Native to withdraw from the relationship. Where non-Native marriages, Native or legal, occur there is a fear that the children will be denied access to the Native culture. Until June 1985, Canadian law enfranchised Native women and their children legally living with non-Native men into the general Canadian socio-political system, but disenfranchised them in their traditional society so that they had no Native rights. When the repeal of the law becomes effective, all Native peoples should eventually have equal rights to being an Indian. A grandmother stated "I hope my grandchildren will be proud of being Indian even though their father's all white".

There are sacred teachings and practices that are part of the culture, "known only to us - the public doesn't see them". To share these "private" aspects of the culture was to lose part of the culture. A similar sentiment was observed when several of the informants refused payment for their participation in the study. They perceived the acceptance of money as selling their culture, rather than payment for their time and effort.

Ethnicity also involves Native relationships within their own group. The Band Council and administration does not always reflect the wishes of the group as a whole. Standing committees are frequently formed by members who disagree with council and how Band monies and resources are allocated. "They think they have a better answer". The members of the standing committee have been known to be

quite aggressive in promoting their positions. This was found to be particularly stressful for elected female counsellors.

Maintenance of group identity also occurs through changing one's Band membership. Patrilocal residence is expected, with the initial move for the woman often being to her parent-in-law's home. Half of the women in the study had moved from another Coast Salish reserve to the Songhees at the time of marriage. When Band membership is changed an application is made to the new Band Council and, when approved, a money transfer occurs from the original Band to the new one. The amount is based on the rights the individual had as a Band member to her Band's economy. For many Bands their income is small, so there is not a lot of money. In the case of one woman the transfer amounted to $1.27 which was paid to the Songhees Band. Without exception, all the women expressed a closeness and loyalty to the Songhees reserve; they considered that it had been good to them; they could not imagine living off the reserve even if something were to happen to their partner or living circumstances. Several had worked at some time for the Band, paid or volunteer, and many had been recipients of services, such as housing improvements and social or health services. A cohesiveness among the community was reflected through the family's commitment to the reserve.

Ethnic Identity Scale

In general, the items comprising the Group Image Subscale of the EIS were ranked lower than those of the other two scales by both childbearing and non- childbearing women. Responsibility for dealing with the problem of prejudice

(Item 1) was ranked first on the subscale, but 8th on the EIS (Table 2). However, it showed a considerable degree of variability, ranking sixth highest (Table 2). Among both childbearing and non-childbearing women responses ranged from not having experienced it, to long stories about a number of specific incidences, including denial of service, unusual surveillance for shoplifting and over "identification" of FAS children. Of significant importance in this subscale was the preference for living on the reserve (Item 12). Although it was seen as very desirable by both groups, but especially the childbearing women, some of the negative aspects such as problems with housing and drinking were also mentioned. However, these concerns were not reflected in the variability (Table 3), and reserve life was seen as an essential factor in maintaining specific tribal and band identity.

Off-reserve living was equated with going the way of the white-man. Maintaining life within the Native community by restricting marriage to Natives (Item 7) was much more important to the older women, although within both groups the women had differing opinions on the desirability of marrying non-Natives, even though they were not in a relationship with a non-Native themselves. Voting for a Native person because of ethnicity (Item 5) and preferring Native friends (Item 13) were of least importance to attaining or maintaining their Coast Salish identity, but there was considerable variability among the older women regarding these issues, especially with preferring Native friends. (Table 2)

In general, there was no statistical difference in the Group Image subscale between childbearing and

non-childbearing women (Table 3). However, as with the subscale Historical Experience, there were notable empirical differences important in interpreting family transmission of cultural values, beliefs and practices between generations and from one environment to another (i.e. between community and individual). The non-childbearing women felt more strongly about voting for a Native, marrying a Native and having Native friends. Their orientation to adaptation to non-Native society and culture change appears to be one of rejection, withdrawal from contact or influence and resistance to participating in the larger society. The younger, childbearing women tend to have an orientation to acculturation, maintaining their own identity while taking on some of the behaviors of the white society, all the while living on their homeland, the reserve.

General Comments - Summary

In general, total scores on the EIS reflected few differences between childbearing and non-childbearing women. The non-childbearing women's strength in ethnic identity relates more to the community level and to maintaining their Native ways, while taking on some of the non-Native ways of life; whereas the older non-childbearing women place heavy emphasis on the family heritage and maintaining the Native way of life through restricting exposure to non-Native society.

Another way of considering the factors of ethnic identity focuses on values purported to be salient to the Native way of life. Analysis of the four subscales (Appendix E) of Social Relationships, Learning, Caring for Others and

TABLE 4

Coast Salish (Songhees) Ethnic Identity Comparison of Mean Scores - Native Value Subscales Childbearing and Non-childbearing women

		Total (Score=60)		I Social Relationships (Score=24)		II Learning (Score=12)		III Caring for Others (Score=12)		IV Traditions (Score=12)	
Women	N	$\bar{X}$	σ	$\bar{X}$	σ	$\bar{X}$	σ	$\bar{X}$	σ	$\bar{X}$	σ
Childbearing	6	45.66	4.63	14.66	2.73	11	.63	10.5	1.87	9.5	1.22
Non-Childbearing	4	45.75	4.19	15	1.41	9.75	1.89	10.5	1.73	9.0	2.45
t-value		-.0311		-.2266		1.5369		0		.4344	

TABLE 5

Ranked Mean Scores and Variance
Ethnic Identity Scale
Native Value Subscales
Coast Salish (Songhees) Women (n=10)

		Rank Order[1]	
Value Subscale		$\bar{X}$	σ
I	Social Relationship	4	1
II	Learning	1	4
III	Caring for Others	2	3
IV	Traditions	3	2

[1]rank ordered from high to low for mean scores and varience

Traditions did not reveal any major differences between childbearing and non-childbearing women. (Table 4) Those scales with the highest mean scores, had the lowest variability, while the lowest ranked scale had the highest variability. (Table 5) While learning is highly valued by both groups of women, they both perceive social relationships to be of less importance. Caring for others was valued more highly by the non-childbearing women, particularly in the area of taking responsibility for the problem of prejudice and discrimination. The subscale Tradition ranked third, and no difference was identified between childbearing and non-childbearing women. These findings are consistent with the previous analysis and indicate the emphasis placed on learning.

Education - Teaching and Learning

Over and over again, through interviews and observations, the salience of education to the Native way of life and being Native was stressed, exclusive of any other factor. "Teaching and learning - it is a way of life for our people - it is experience and listening to the wisdom of our parents and ideas."

The process of educating includes ongoing, repetitive communication, socialization and enculturation. It was considered to be primarily the responsibility of the family, especially grandparents and to a lesser, but significant extent a function of the elders. With the elders, however, the responsibility was clearly put upon the individual to listen to the elder who is seen to be readily available as a teacher, whereas the family was expected to assume the responsibility for teaching the family members,

and in a way making sure they listened. If planning teaching is perceived as the responsibility of the family, imparting wisdom the responsibility of the elders, and listening the responsiblity of the child, monitoring adherence to the teachings may be perceived as the responsibility of the community in general.

Education

The goal of education was defined as being able to live like your mother, father or esteemed relative whose name you might share. "Thank you for behaving like your father" was a compliment to the family, since it signified that they had taught their member well. Legends were taught to children, especially at puberty, so that they would learn to be better than they were at that time.

There is a belief that being mature is a way of thinking about one's self and of doing things and that the feeling of wanting to be Native is imperative to learning. Timing of teaching is also considered to be of critical importance. "Teaching cannot be turned on just like that - parents, grandparents and elders teach you when it is time." Thus, one has to be there, not just physically, but mentally as well, when it time to listen to the teachings. There are no structured classes and no defined times. It is, in part, the responsibility of the individuals to be in the right place at the right time. Several men and women stated how they had not been ready to listen when they were younger, but were now actively seeking opportunities to be around older people so that if the right moment for teaching came they would be there. The younger childbearing women did not mention this; whereas the older non-

childbearing women remarked about learning from their grandparents and now trying to teach their grandchildren and children.

Education is considered a way of life from conception to death. "The first day of conception is the first day of training." It is believed that one starts to learn before birth, and what the mother does, sees, feels and learns influences not only the baby, but its later life. Learning continues through stages of the Circle of Life. It is never ending. Parents are expected to be teachers continuously, on an everyday basis, 24 hours a day. They continously talk to their children, regardless of age, for even the adult needs teachings especially in times of change and crisis.

Elders are there to be listened to and share their wisdom from past experiences. They are believed to have an inherent knowledge of how one feels and therefore should be listened to when they have something to say.

There are many rules, rituals and disciplines to be learned that are important in daily life from the unborn to death. As one parent expressed it "I cannot teach you everything now - I would need four seasons to teach the disciplines, and then there are always the lectures - like at marriages and in the Longhouse". For the Native person, these rules are imparted by parents continually talking and demonstrating by example.

Teaching

The two major teaching methods were found to be oral

communication and role modelling. When describing one's Native education, distinctions are made between it and "English education". It is not "book learning"; it is the stories, legends and lectures about the teachings and disciplines told over and over again by parents, grandparents and elders. It comes by word of mouth and "is prepared from the heart". It is repetitive. Parents and other family members act as role models. The child observes how the mother acts toward the family and the children, while other times is shown explicitly how to do things, such as prepare Native food. Older sisters and young mothers demonstrate through everyday living the skills and attitudes required for being a wife and mother. Several of the women learned about "becoming a woman" from older sisters, and what it was like to be pregnant or breastfeeding from watching their own mothers or older sisters.

Learning

Learning is believed to occur in two general ways, and to some extent these are fostered through teaching methods. Primarily one is expected to learn from experience, to start participating early and to get involved. Help or assistance is sometimes offered, but the teacher must be careful not to "push oneself on them (the children), they are never told they have to do anything." Emphasis, instead, is placed on the individual for being responsible for him/herself and for learning from mistakes. This was evident as women of childbearing and non-childbearing age told of their lifestyle behaviours around smoking, drinking and sexual activity. The women would all know what their parents thought of the various practices and had been told

that if they decided to engage in the practice they would have to assume the cost or the consequences, but in no instance was the woman forbidden to do anything. The situation was similar for pregnancy. As long as the Native teachings were followed, and in this case the mother or grandmother did watch over the woman, the woman learned about what it was like to be pregnant or in labor as she went along.

The second mode of learning was called "common sense". It is expected, by some, that if an individual gets into a particular situation such as pregnancy or child care, that s/he will have the common sense to know what to do, or else s/he would not be in that situation. Besides being an inherent quality, it is also believed to come through patience and waiting: the acquisition of wisdom. This mode of learning might be considered passive in contrast to that gained through experience.

Adherence

Stories, legends and teachings are told hundreds of times over, not always exactly the same, otherwise interest would be lost, but they are repetitious throughout one's life.

> We need to be reminded not to be annoyed, but to listen, for it is difficult to practice what you know. Old people are always telling us 'don't get tired of it - hear it again - keep it up.

There is a concern about the young people now: a concern that there is too much TV, too many movies and too little listening to parents and elders. A grandmother, speaking for many parents and grandparents, expressed concern when this occurred during pregancy. "Its true - I've seen it - when the mother doesn't care for herself." She was talking

about adverse outcomes of pregnancy when the baby displayed various behaviors associated with violation of the teachings regarding nutrition or emotional health. "That's why my mother-in-law was really strict with my first pregnancy - and my mother reinforced it - wanted it done right."

Besides other family members having a role in encouraging adherence to teachings, the whole community is expected to do so. Apparently this occurred more regularly in the past, but is still evident as community members point out to individuals when their behavior is not acceptable to Band life. They teach children as they come in contact with them in community life. Adherence to teachings is encouraged for personal healthy growth, for responsible participation in family life and for living a Native way of life.

Communication

Native people's style of communication was found to differ from that of the non-Native, and certainly from that of the white, middle-class health care professional. How teachings are communicated is worthy of a study in itself. What is important to this study are some of the characteristics noted that facilitated the investigator's access to information and understanding of the content of the teaching.

Willingness to talk about one's experiences cannot be equated with openness to sharing all the salient values and beliefs, or even practices. "There are things in our culture which can't be shared - its okay what I've told you so far". Respect for their view that "by letting the ways out, we may lose" meant not probing with specific questions past certain points; accepting the fact that some things in

the culture - practices and beliefs - are sacred because the general public does not see them: they are part of the Native culture, known only to them. The same thing was true of some family teachings, such as family medicines, songs and dances. These teachings cannot even be shared with other Band members.

When talking about their culture, the Native peoples take it very seriously. They make a determined effort to recall teachings accurately and in the right context. Both childbearing and non-childbearing women remarked upon their activities between arrangements and the actual visit(s) for the study. They at first did not think they had anything to tell the investigator, so they did a variety of things: thought back through their own experiences, talked with other Band members or read something written by a Native. This last activity was not very prevalent - some women could not read English and there are few articles or books written by Natives. Other informants spoke of their preparation for workshops or conferences. Preparation included purification rites, meditation and fasting

> just so the words would be true - if we make a mistake in our Indian society it costs my family a lot of money. Those are the rules. That's how sacred it is.

When speaking of their culture in front of other Native peoples, they frequently validate what the others have said.

However, when someone is speaking of their personal experience or views, other Native peoples make no attempt to ask for clarification, build upon or contradict that which has been previously said. Each individual is allowed

to indicate a state of readiness to express an emotion, feeling or idea. No attempt is made to hurry the person along, assist with "finding the right word" or assume that the person is finished. Silence is respected and only interrupted when the person indicates that she has finished speaking.

Another characteristic of communication among the Native peoples is the recognition that everyone has something to say, but not all are ready to speak at the same time. The communication process is not complete however, until everyone actively involved in the situation has spoken. Thus, near the end of the process, those who have not spoken will likely be invited to do so; and indeed they generally have something important to contribute but have waited until it is timely to do so. Everyone is dealt with on an equal basis; no one is considered the expert.

Interviews

Content analysis of interviews with the women suggested that the educational process regarding childbearing could be categorized according to:

1. the degree of commitment they felt to the teaching;
2. the source of teaching;
3. timing of the teaching;
4. expected recipient of adherence to teaching;
5. teaching method;
6. type of message;
7. readiness to learn;
8. readiness to teach.

Each area of childbearing teachings within the Medicine

Wheel was so categorized. As well, there were some general remarks made by the women regarding teaching In Native ways, some specific to women. It is this general orientation to education that is presented in this section.

Continuum of Commitment to Teaching

The continuum of commitment ranged from low to high. The five points on the continuum were:

Level 1) Told only - the woman recounted the teaching or belief, but gave no interpretation.

Level 2) Told and interpreted - the interpretation of the belief or teaching included superstition, belief in, or confusion because of conflicting belief.

Level 3) Teaching or practice and outcome noted - the woman implicty linked belief and outcome, but drew no explicit association or explanation between the two.

Level 4) Others practice it - the woman noted the value that others placed on the belief by their practice, but did not indicate her own value.

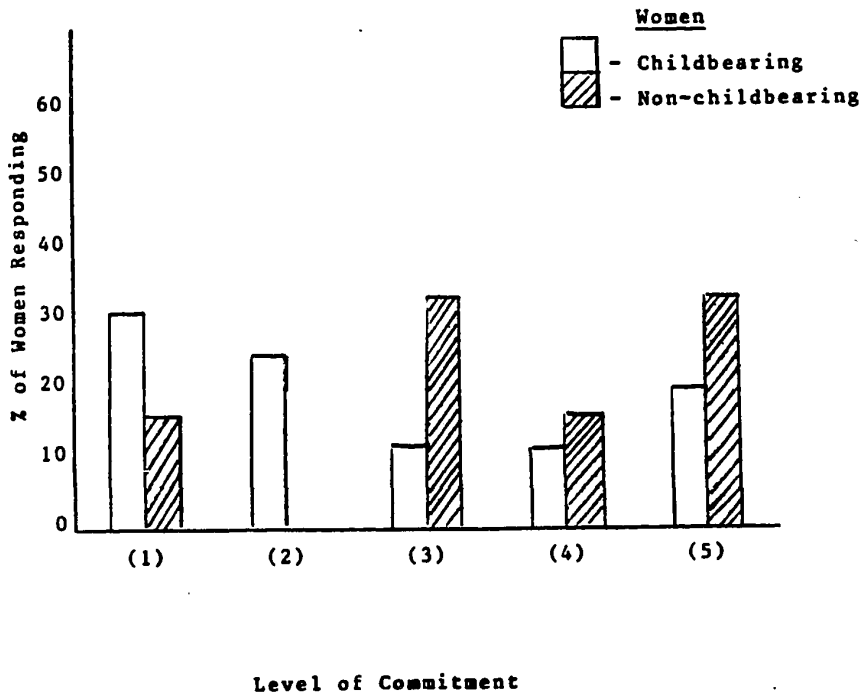
Level 5) Practiced teaching - self practice was the highest level of commitment to the belief.

The majority of the childbearding women indicated a low level of commitment at levels 1 or 2 to general teachings; whereas the majority of non-childbearing women were committed at levels 4 and 5. (Figure 10) However, those childbearing women who were committed to practicing the

FIGURE 10

Level of Commitment to General Teaching and Learning

Childbearing (n=6) and Non-Childbearing (n=4) women



teaching, told of practicing them more than the non-childbearing women, which may have been a function of their recent involvement with childbearing.

Source of knowledge

The primary source of general teachings was the mother for both childbearing and non-childbearing women. Grandmothers were the second most frequently named source for non-childbearing women, whereas the nurse was almost as frequent a source as the mother for the childbearing women. Generally, non-childbearing women indicated that their source of knowledge was gained through experience. This was the third most frequent source stated by these older women. For the childbearing women, sisters, doctors and their own experiences were the third most frequent sources of knowledge in general.

Timing of teaching

The majority of teaching occurred at the time of the event, or when the need arose, for both groups of women. However, general teachings throughout life, and particularly during the childbearing period, were identified by the majority of childbearing women.

Expected recipient of adherence to teaching

There was considerable variation in this category for the general teachings. The most frequent recipient was the pregnant women, but the baby, child and adult self were also identified by all women.

Teaching Method

The teaching method most childbearing women described was an informal one that was none the less explicit in the message conveyed. The occasion was unplanned, usually a part of a daily activity and the message was concrete. As well, many of these women mentioned a more formal teaching method, where concrete teachings were delivered in the form of lecture, either by parents or elders, or they had themselves sought out more formal occasions to learn about the Native ways. The older non-childbearing women also spoke of the informal method, but included in it another aspect - a more implicit orientation to the message. The teaching was abstract, often told in stories and myths to illustrate Native beliefs and values. Both groups of women described the absence of teaching about specific changes that could be expected with menarche and pregnancy. It was difficult for most of the women to use proper names for the physiological processes and anatomy involved. They suggested that the absence of teaching was due to their own parents' discomfort in discussing these "sensitive" issues. The teachings for the disciplines required during these times did not seem to connote the same degree of embarrasment.

Type of message

The types of messages most women described could be categorized as advice, instruction and information. All were of equal significance to childbearing as well as non-childbearing women. Sharing of concerns was not seen as an important type of message to be commmunicated in the teachings.

Readiness to learn

There was equal variation among both groups of women regarding their state of readiness to learn. Some described their state as not being ready, not listening and now wishing they had. Others said there was always something to learn and were generally ready, but not seeking. For the remainder, theirs could be categorized as high readiness. They were seeking opportunities. All the non-childbearing women and one third of the childbearing women gave the reason for not learning as having been in residential school. Not only were Native teachers not available, the women were not allowed to practice what they had known.

Readiness to teach

Only one childbearing mother suggested that she was ready to teach others. She was employed by a Coast Salish Band as a school teacher working in a Native school. All the non-childbearing women gave some indication of wanting to teach, but waiting for the right moment having done some teaching or actively seeking opportunties and taking advantage of those that presented themselves. Generally speaking the teaching was aimed at children and grandchildren.

Summary

In general, identity with the Native way of life was very strong in the positive direction, with little if any overall difference between childbearing and non-childbearing women or between the women and the informants. Group image was most important to the

non-childbearing women, while historical experience was most salient to the younger, childbearing women, faced with the future, if not immediate, need of teaching the Native way of life to their children. The value placed on learning their Native language, helping others and observing Native customs was evident in both personal interactions and observations in the daily and ceremonial life of the Coast Salish peoples. On the EIS these values showed the least variance. Restricting one's social life and health seeking behavior to only involve Native peoples was considered by some as desirable and by others as a liability. Overall, it was of least importance to the maintenance of Native identity.

Self Concept

At the core of the woman's own Medicine Wheel is her self concept, the result of the personal intergration of mind, body, spirit and environment. It is organized around the beliefs and feelings that one holds about oneself at any given point in time. The dynamic quality of one's self-concept reflects the continuous interaction between the woman's past experience and expectations of the future, combined with the process of current social interaction. Surely, as Storm so poignantly states

> In many ways this Circle, the Medicine Wheel, can best be understood if you think of it as a mirror in which everything is reflected. 'The universe is the Mirror of the People,' the old Teachers tell us, 'and each person is a Mirror to every other person' (Storm, 1972; 4-5).

A Native perspective of self-concept as a theory, or idea,

was gained through general observations, interviews with informants and women and administration of Rosenberg's Self-Esteem Scale with two Native-oriented items added. (Appendix D) Content analysis of the observations and interviews identified categories consistent with the directions of the Medicine Wheel. Material-self included one's view of one's body, family and possessions. The social-self reflected the views others' held about the woman and the woman's view of herself in social interaction. Emotions, feelings and desires comprised the emotional-self, while the spiritual-self included how one viewed oneself in a religious context and whether one recognized a personal special spirit, strength or power.

The self-esteem scale (SES) was analyzed according to Rosenberg's Scoring in sub-scales (Appendix F) and the two added Native items, as well as a total score. As the Rosenberg subscales were not reflective of a Native orientation, an alternate set of subscales was developed, based on values and concepts found to be salient to the Native way of life (Appendix G). The two added Native items were included in the appropriate subscales. The subscale "On the whole", or generally or basically speaking was based on the Native people's orientation to wholeness and integration, and the fact that some things cannot be dissected apart. Items 1, 9, 10 and 12 comprised this scale. The second subscale "at times" is based on concepts of continual growth, improvement and relevance to the context at the time. It reflects the notions of striving and recognizing strengths as identified in items 2, 3, 5, 6, 8 and 11. "Compared to others" is the third subscale. Native peoples see themselves as being part of a larger whole, equal to others, but not competitive. Items 4 and 7

are included in this subscale. Generally, the self-esteem scale provided another measurement of the social-self and emotional-self of the woman's self-concept.

Material Self

Very few references were made to one's body, and when they did occur it was generally with respect to being pregnant. Only one woman remarked about liking to feel healthy, being active, busy and strong and caring for her family. Weight gain and feeling tired during pregnancy were identifed as two reasons why one's self-concept was altered in a negative direction. However, just as frequently the woman stated that being pregnant did not cause any changes in feelings about herself.

The three major material-self subcategories were family, work and education and possessions.

Family

Babies and children are considered a source of pride, a demonstration of doing something well. The importance of being a member of a particular family, i.e. "my family", and knowing one's heritage is demonstrated by the comment,

> when you are establishing your identity with another Native who doesn't know you, then you go through your father, or grandfather, if he is alive. 'I'm the daughter of_____'. After you do this you could also go through your mother's family.

It is also an honour to have your behaviour or respect recognized as that similar to your father's, that is you

are thanked for behaving like your father. These findings were representative of informants and all women interviewed, regardless of age.

Work and education

Upgrading, acquiring new skills and putting the knowledge and skills into practice were particularly important to the older women and informants, but not indentified by the younger childbearing women. Once training was finished it was important to the woman to obtain work and use those skills. One woman spoke, with regret and some frustration, that her husband could not see why she wanted to work as long as he had a job. She did not go against his wishes. The training, viewed as important by these women was in people-oriented service areas such as homemaker, nurse's aide, home-school coordinator, and community health representative.

A positive self-image was engendered not only by using one's acquired knowledge and skills but by working as well. Employment gave the women an independence from social assistance. Being able to support oneself or family and carry through with the responsibilities of the job were identified as important to the older women.

Possessions

Possessions included family or personal art, family photographs, diaries and personally made crafts. Two of the non-childbearing women thought they could knit the best sweaters, and gave reasons why they thought so. A young mother proudly showed her paintings and illustrations in a Native art book. Family gifts also contributed to the Native people's self-concept and were shown with pride to the investigator.

Social Self

Although material sources of the self-concept were mentioned, these were not to intrude upon one's relationships with others. A father spoke of the situation in this way, "you should always be a small person, make yourself as little as possible". In other words, a positive self-concept is not gained through boasting of one's accomplishments or family. In fact, it was suggested that improvement and growth could take place "through relationships with weaker people, because then we are brought face to face with our own weaknesses". Praise from others is not given indiscriminately, but rather when it has been well-earned and the task has been completed. The same principle applies to criticism.

A recurring theme was the need to carry one's self well in all areas of daily life, especially showing respect for elders, since this in turn determined how others thought of you. A young mother described the embarrassing and distressing experience of a Native woman who was accused by a non-Native social worker of abusing her children. Her response was to suggest that the situation resulted from the social worker's lack of understanding. "You should look on all sides of people" implying that the social worker had not explored the whole situation, but judged the mother in only one part of her daily life.

Being a woman carries special responsibilities. The degree to which she meets these responsibilities contributes to her self-concept in a positive way. Motherhood and grandmotherhood are important sources of validation of one's social-self. Being called "grandmother" by the children on

the reserve, or "mom" by a non-Native son-in-law were indications of a positive view held by others. On the other hand, the role of women in getting social and recreational matters attended to by Band council was recognized as very important, but the negative view was that most of the women would not accept this responsibility and were viewed as TV watchers, not knowing what else to do with their time. Thus, the opportunity for improving one's self-concept in Band social life was taken by only a few women.

Emotional Self

Many of the feelings related to the emotional self were of a negative nature. Women of both childbearing and non-childbearing age most frequently mentioned a lack of self-confidence as diminishing their self-esteem. Other negative feelings were failing self-respect and disappointment or guilt related to their behavior e.g. in labor, or their baby's condition e.g. jaundiced at birth, crying with immunizations.

The desires, however, contributed to a more healthy self-concept. Wanting to do better, striving for healthy relationships and learning from other Native's mistakes were frequently mentioned by women and informants. The underlying philosophy was that, "you have to take care of yourself, because no one is going to."

Spiritual Self

The basis of a positive spiritual self seemed to be feeling good about being Native. For some this meant recognizing

that "something" was missing in their lives and actively seeking the answer in Native ways. The outcome was a positive self image resulting from accomplishments never before considered achievable. For others, it meant dealing with conflicts over values: one's own and the Native teachings, with resolution leading to a peace of mind. Turning away from the family or Native ways was described as "losing one's soul," and being in a trance. Thus, the spiritual self was closely identified with being Native and with one's ethnic identity.

Self Esteem

Item analysis of the SES with rank ordering of means and variances revealed a tendency to greater variance among the women with respect to the more negative rather than positive factors (Table 6). The more negative factors (Items 2, 5, 6, and 8) received the lowest scores for the older non-childbearing women; whereas the younger women ranked needing more self-respect (Item 8) and wanting something to be proud of (Item 5) as important to their self-esteem. In general, the positive factors of self-esteem shared the least variance, and most women were in agreement that doing things as well as most other people (Item 4) and feeling as worthy as most (Item 7) were very important factors contributing to their self-esteem. Satisfaction from daily work was rated low by both groups of women. Overall, the older women consistently rated the positive factors contributing to self-esteem as more salient than the negative ones. On the other hand, the childbearing women's self-esteem reflected both positive and negative factors as being equally important. They did not see themselves as positively as the older women.

TABLE 6

Ranked Mean Scores and Variance of Self-Esteeem Scale

Childbearing and Non-Childbearing Women (n=10)

Scale Item	Rank Order[1]	Childbearing Women (n=6) $\bar{X}$	Childbearing Women (n=6) σ	Non-Childbearing Women (n=4) $\bar{X}$	Non-Childbearing Women (n=4) σ
1. Self satisfied +		10	7	4	10
2. No good -		12	6	8	6
3. Good qualities +		7	8	7	4
4. Similar to others +		4	9	1	12
5. Not proud -		2	11	11	1
6. Feel useless -		8	5	12	9
7. Worth, equal +		5	10	3	3
8. More self-respect -		3	2	9	2
9. Failure -		1	12	6	5
10. Positive self attitude +		6	4	5	11
11. Get along well +[a]		9	1	2	8
12. Daily work +[a]		11	3	10	7

[1] rank ordered from high to low for mean scores and variance

+scored as a positive factor

-scored as a negative factor

[a] native generated items added to Rosenberg's Self-Esteem Scale

TABLE 7

Coast Salish (Songhees) Self-Esteem
Comparison of Mean Scores - Rosenberg Scales
Childbearing and Non-childbearing Women

		Total (Score=12)		Rosenberg Subscales I (Score=2)		II (Score=2)		III (Score=2)		IV (Score=2)		V (Score=2)		VI (Score=2)	
Women	N	$\bar{X}$	σ	$\bar{X}$	σ	$\bar{X}$	σ	$\bar{X}$	σ	$\bar{X}$	σ	$\bar{X}$	σ	$\bar{X}$	σ
Childbearing	6	11.5	1.2247	2.0	0	2.0	0	1.83	.4082	1.83	.4082	1.83	.4082	2	0
Non-Childbearing	4	10.75	.9574	1.75	.5	1.75	.5	2.0	0	1.5	.5773	2.0	0	1.75	.5
t-value	10	1.0265		1.2652		1.2652		-0.1949		1.068		-.8161		1.2652	

When the self-esteem scale was scored according to Rosenberg's directions and subscales (Appendix F), both groups of women demonstrated high scores on the subscales and little difference existed between childbearing and non-childbearing women (Table 7). On the total scale, childbearing women tended to have higher mean scores than the non-childbearing women, somewhat of a contradiction to the item analysis.

For this reason, a different method of scoring and differentiating subscales were developed based on Native values. (Appendix G) Analysis revealed similar results to the Rosenberg Scale. Childbearing women had higher mean scores, but greater variance than the older women on all the subscales, as well as the Native items and the total scale. (Table 8)

Summary

No statistically significant differences were found between the groups on the self-esteem scale. All women tended to have fairly high self-esteem, even though the younger ones felt they had some negative qualities which required change. These findings support those of the interviews and observations with respect to the emotional self. Taken holistically, the women demonstrated positive self concepts, while recognizing that some aspects of the self required improvement, especially the culture-specific ones, such as gaining self-respect as a Native woman, understanding one's heritage better and developing healthy interpersonal relationships.

TABLE 8

Coast Salish (Sonhees) Self-esteem
Comparison of Mean Scores - Native Value Subscales
Childbearing and Non-childbearing Woman

		Total (Score=48)		Native Value Subscales A. On the Whole (Score=16)		B. At times (Score=24)		C. Compared to Others (Score=8)	
Women	N	$\bar{X}$	σ	$\bar{X}$	σ	$\bar{X}$	σ	$\bar{X}$	σ
Childbearing	6	39.67	7.005	13.17	2.994	19.17	3.545	7.33	.8165
Non-Childbearing	4	36.75	3.862	12.0	1.414	17.25	2.986	7.25	.9574
t - value		.7512		.7192		.8888		.1421	

CHAPTER VI

CHILDBEARING AND THE DIRECTIONS OF THE MEDICINE WHEEL: A HOLISTIC NATIVE PERSPECTIVE

Childbearing was considered by the Coast Salish peoples as a natural, expected and significant part of the Cirle of Life. Primarily it was the domain of women, but men also believed that pregnancy, birth and postpartum required recognition and disciplines on their part. They too had teachers and advisors regarding their behavior during this vulnerable period. But in general, the men were not privy to the teachings, disciplines and personal experiences of the women.

There was, and still is, the belief that women during menarche, menstruation, pregnancy and the post partum period are not only more susceptible to the influence of the total environment and their own individual spirit, but that they had increased powers over others. It was not so much that they are perceived to be unclean, rather they are the newly acquired spirit of initiates and dancers.

The significance of the childbearing period is reflected in each direction of the Medicine Wheel, both for the woman and her family. (Figure 2, Chapter II) Because major events of childbearing take place between the woman and her family involvement, this chapter analyzes the data with respect to the four directions of both the family and individual Medicine Wheels. The Medicine Wheel of the Songhees community was described in Chapter IV as the

context in which to understand the family environment and the transactional processes of ethnic identification and education which influence the individual woman's general growth, development and health. The elements of each direction of the Medicine Wheel will be referred to in this Chapter as each is significant to the childbearing process of Songhees women.

North - Power of Wisdom: Building Physical Health

The Family

The elements of the family's Medicine Wheel that were identifed by content analysis were home characteristics, family membership, foster and child care and material resources. There were similiarities as well as differences among the Songhees families.

Some of the families lived in mobile homes and some in one or two story frame constructions. The childbearing women lived in the mobile homes, except for one who, with her partner and baby, lived with her family of orientation in a frame constructed home; whereas the non-childbearing women all had permanent homes. An adequate supply of considered to have the power to negatively influence the success of hunting and fishing, the strength of the men and housing has been a perennial problem on the reserve, so it is reasonable that the younger families would have the more temporary accomodation. All the homes were on reserve land

and had access to two main city roads via the gravel reserve roads and lanes. In the dry season, dust stirred up with vehicles and wind covers the blackberry bushes, overgrown weeds and wild flowers and abandoned vehicles in family yards and reserve fields.

The exteriors of the homes are as varied and personal as the interiors. Although it is not unusual to find stairs without railings, yards with discarded equipment and children's toys, and walls lacking siding or paint, a productive vegetable garden, artistically painted door and neatly piled firewood next to the house are common sights. Where one person's yard begins and anothers ends is sometimes questionable, but apparently not of great significance.

Without exception all homes had the basic conveniences of kitchen appliances, plumbing and electricity. Of concern to the larger families, especially those where three or more generations lived together, was the space situation. The problem as they saw it was a lack of privacy, not being able to get off on one's own or being assured of uninterrupted time by one's self or with one's partner. A common factor in all homes was the inevitable television. It was always on, and only occasionally turned down during a visit; seldom was it turned off. On two occasions in different homes, interview times were scheduled around viewing "The Soaps".

All homes reflected a family orientation to the Native culture. Some form of Native art or crafts was on display,

usually alongside large photographs of past and present family members. Identification of the photographs was made with pride and accompanied by detailed accounts of the geneology. In homes where the Shaker religion was practiced at least one member, there was a special area arranged as an altar. Other material possessions were at a minimum. The furniture was adequate, functional and usually well worn. No distinctions were made as to who could use the furniture, nor the kinds of activities that were appropriate. Children, as well as adults, ate, slept or socialized wherever they chose. The home might be described as truly multifunctional.

Family membership in the home ranged from an elder living by herself, to a family comprised of three generations: three marital relationships and two parent-child families. However, most of the childbearing women lived with their partner and child(ren), with other family members living in homes nearby. No childbearing women had foster children living with them, but all the older non-childbearing women spoke of having fostered children at some point in their lives.

Family perspectives on **childcare** differed considerably. Understandably the families of childbearing women were most concerned about the current needs of their children, the milestones they were reaching in growth and development and the perceptions others had of the situation. Of particular concern was how the family's parenting role and abilities were viewed by non-Native health and social care workers. Several mothers remarked on how they thought nurses were

ridiculing them because they did not follow through on behaviors that they perceived the nurses expected. One mother could not go to the nursery to view her newborn under the bililights because she felt guilty about having possibly caused her baby's condition.

Another mother put off taking her infant to the immunization clinic because she could not bear to see her hurt and crying. The families, and especially the mothers, perceived the nurses' reactions to be non-supportive. It was the children's grandmothers and aunts who in the end took on the required parenting role in each of these situations. Another mother referred to her fear of being accused of child abuse or neglect because her Native childcare practices differed from non-Native ones. "We make sure the children will be looked after if we are going to drink on the week-end. We (i.e. Native peoples) don't neglect our children - they are always looked after. Emotionally you might think we neglect them - they want to do things and we won't let them". Neither nursery nor day care was mentioned by anyone as a source of childcare. Although there were no child care facilities on the reserve, there were several near the schools attended by the older children. Instead children were looked after by their grandmothers, aunts or siblings. It was not unusual to see a young girl, maybe 10 years old, looking after several two, three and four year olds, and doing so quite competently without any fuss.

Families of the childbearing women tended to approach childcare issues using a "trial and error" problem-solving approach. They relied primarily on the advice of relatives who were also experiencing the parenting or childbearing

roles and on their own intuition or common sense; only after that did they seek advice from the Community Health Representative. When the problem persisted, usually the doctor and infrequently the community health nurse, was consulted. Taking children to the hospital was viewed as "having them taken away". Therefore, mothers tried to look after their children as much as possible in the home. Perceived problems included physiological concerns such as constipation, physical characteristics such as gum blisters and milia, and care advice regarding the cord and weaning. Except for the mother living with her extended family, mothers were not a source of information regarding child care.

The older women and their families believed that child care and discipline had become too lenient with the present generation and that the children were not as healthy as in the previous generation. One of the major reasons identified was poor teaching. According to these women, the children are not taught to obey the elders and to "be seen but not heard". Rarely do the children play outside in all kinds of weather and when they do they are bundled up too much. The non-childbearing women talked of the traditional teachings of childcare and how these prepared the child to handle her/himself in the environment.

From birth, infants were looked after on cradleboards. Although no specific reason was given, an elder said it was "helpful - could tell by the physical and emotional development of children". One elder suggested that use of the cradleboard and firm wrapping resulted in a quieter, calmer life later on. The advantage of cradleboards was the fact that they could be taken anywhere by the family:

carried by hand or on one's back, propped up when the baby was awake,and laid flat for sleeping. A rolled diaper was put behind the neck of the baby when lying on her/his back "so that the baby would have a neck". The baby was wrapped securely, with the arms at the sides and legs wrapped together. It is believed that wrapping the legs prevents bowlegs and club feet. Firm bundling makes the babies feel secure when they are placed in the cradleboard. They are turned frequently so their heads do not become mishapened. One childbearing mother had been given a beautiful cradleboard by a relative, but was admiring rather than using it.

After birth the baby was to be rubbed with oil, or to have the skin rubbed with black stones. Both practices were undertaken to make the skin smooth. At the same time massaging the baby in specific ways was advised to shape the eyebrows, eyes and cheeks.

There were also teachings about cord and umbilical care. If the umbilicus stuck out, a quarter was put over the cord and the baby wrapped around the middle. If left untreated it was believed that the baby would never be satisfied. When the cord fell off, it was to be put in a high place, out of reach. Later it was to be tied to the baby's back so that s/he would not always be looking around and wondering where to go as if lost. One of the childbearing women said that she believed this, but was not sure if she would do it. Another practice was to bury the cord some place near the house where it would not be disturbed. If this was done so that the child would "have his feet firmly on the ground".

One of the older women had taught her daughter about looking after diapers. They were never to be put on the floor, regardless of whether they were clean or dirty. This practice was to prevent the child from growing up wanting to eat things off the floor. Her daughter did not follow the advice and now "the baby is always picking things off the floor to eat - I told her so".

As well as providing the physical home environment for the mothers, structure for the members, and refuge when needed, the family was an important source of **support** with respect to material and instrumental resources. When potlatches, or other ceremonies were given, the family was re sponsible for raising the money, making gifts and providing food. All family members participated under the direction of designated individuals, such as the father, uncle or grandmother. Families kept accounts of where the money came from so that when the time came to return it when another family was raising money, the original contribution and more was repaid. A comment would be made by the family that what had been leant was being repaid. The loan could also be replaced in kind. At a recent family memorial ceremony, the families from both sides helped, "returning favours that had been done for them in the past". A brother and his son supplied a deer; other relatives brought in bags of clams; sisters and cousins made gifts of beadwork; while other relatives helped in the preparation of food. Based on past experience and recognition some members took more of a leadership role than others.

Sharing material goods and providing physical aid are cornerstones of Indian society.

> One time, whenever there was a need in our community, our people would come together, you'd be sent to invite your grandmothers, grandfathers and aunts. The people would come together with the elders in the Longhouse. The family cared a lot. A lot of people would come and lecture and talk. If it was decided you should have your own house, the community would do that together. When I have something to do I go and invite my friends and relatives and I go to my partner".

But the extent of this communal concern and sharing has lessened according to some of the younger informants. There is a tendency to "live my life like a vacuum".

However, from observation of daily reserve life and ceremonial behaviors, sharing remains a valued practice. It is expected of young and old, men and women; it is accepted without much obvious acknowlegement. Content analysis of the interviews indicated that of all the types of social support that could be given (i.e. sense of belonging, information and material aid), material aid from the family was most often mentioned by the women, and almost always the aid was given and accepted spontaneously. The older women frequently talked about the help they gave to their children, or other family members, while the childbearing women acknowledged receiving money, goods and child care primarily from other women and especially their mothers. Financial aid was the most important kind of support - money for trips, baby equipment and household expenses.

Regardless of the type of material aid provided, the primary reason for doing so was because it "was family". Family child care was important to the childbearing woman and she felt free to ask her family members to do this.

Where hesitancy entered into requesting or accepting this type of support, it was due to the woman's feeling of concern or guilt for leaving her newborn baby. These feelings did not persist as the baby got a little older and was left with kin.

The physical care given to children, i.e. bathing, feeding, washing clothes and babysitting was similar to that given to family members in times of sickness. Many of the older women described the care they gave to sick family members, either living in the home or even on another reserve. One elder told of travelling up-island five to six times a week to visit her sick brother. She would prepare his favorite foods and then help with some of his physical care when she got there, even though his wife was around. The elder also arranged and paid for several Shaker healing ceremonies, as well as a visit from an "Indian doctor" from the United States.

The family's physical environment may be considered to be a microcosm of the Songhees reserve. The interior and exterior of the home reflects the general character of the reserve land and buildings; the family care function is similar to that of the Band and its Native Community Health Representative and Social Workers. As with the Band, the philosphy is that "we look after our own". Sharing material aid with family members is consistent with the way in which Band finances are to be handled - every one is entitled to assistance and when the need arises more assistance is given without worrying when or how it will be repaid or returned. This is the environment the woman is surrounded by during childbearing; an environment that translates Coast Salish expectations into daily activities

and teaching required for healthy pregnancies: an environment that offers degrees of support or hindrances for carrying out the practices.

The Woman

Childbearing beliefs, values and practices that are salient to the physical direction of the woman's Medicine Wheel relate to diet and nutrition, activity and rest, labour and delivery and breast feeding. The teachings were almost exclusively of a traditional nature, rather than identified as contemporary. Those that were not related to a traditional source were suggested to have emanated from one's self - one's intuition. It was previously noted that some Native peoples consider "common sense" to be a prerequisite or corequisite to becoming pregnant and caring for one's children. Common sense and intuition are innate qualities - possibly related to one's "sinuit".

Of all the childbearing teachings, those related to **Diet and Nutrition** were the most numerous, and with few exceptions those that caused the greatest dilemmas for the women. They were unsure of the validity of the requirement and whether-or-not to practice it themselves. Many of the teachings were similar to those of menarche. When the women recounted the teachings there was a great deal of consistency in their accounts of the practices required and outcomes affected. However, there was considerable diversity in the explanation given for the effect, and in many instances no explanation was forthcoming.

The diet and nutrition beliefs and practices were analyzed according to the following categories: continuum of commitment, source of knowledge/teaching, timing of

teaching, expected recipient of adherence to the teaching, type of change the teaching prescribed and the content of the teaching. Similarities and differences were noted between the two groups of women, childbearing and non-childbearing, and between the women and other informants. In general, there was a great deal of consistency regarding the content and source of teaching, as well as the expected recipient. As could probably be anticipated, the greatest discrepancies were found in the degree of commitment to the teaching.

Interpretation of quantitative data analysis is done with considerable caution since there had been no attempt to count frequencies or quantify responses during the interviews. Thus, the quantitative data supplement the qualitative, providing another perspective to understanding the teachings and practices of the Songhees Coast Salish peoples.

As was found with "Education - Teaching and Learning", the degree of commitment to the teaching ranged from high to low along a continuum. Level 1 (the lowest) indicates responses where the teaching was recounted, but no outcome noted; level 2 responses gave the teaching and suggested some interpretation - i.e. conflicted with other teachings, superstitious nature of it questioned. When the teaching or practice and outcome relationship were noted implicitly, the degree of commitment was rated at level 3. Describing the teaching and identifying others who practiced it was the next higher level of commitment; while level 5, the highest, included those responses where the women acknowledged the teaching and their own practice of it.

About one third of the childbearing women identified diet and nutrition teachings that they practiced, about the same number who noted the teaching and outcome implicitly but not their own particular practice. (Figure 11) Only about one quarter of the childbearing women described teachings without noting outcomes or practice. A few suggested that conflicts arose with these teachings and others possibly emanating beyond the Native community. Two conflicting teachings came from community health nurses. They encouraged increasing the diet with milk and liver. Milk is not well tolerated by Native peoples and eating organ meats is restricted during the childbearing period.

When considering the total numbers of teachings described by the childbearing women, almost one half of the teachings were self-practiced. (Figure 12) Again there were few teachings on the lower end of the commitment continuum, whereas about one quarter were in the middle when the teaching and outcome were noted implicitly. It was common for women to describe the restrictions on eating strawberries during pregnancy. At some other point during the interview the women would point out a "strawberry mark" that they or one of their children had, but they didn't explicitly state that this was caused by, or due to, strawberry consumption during pregnancy. On the whole, childbearing women shared a considerable commitment to the Native dietary teachings. The greatest degree of commitment related to teachings of restricting seafood and berry consumption.

The older, non-childbearing women also showed this tendency to commitment to the Native teachings. (Figure 11) However, since they were no longer in the position of

FIGURE 11

Level of Commitment of Women to Diet
and Nutrition Teachings
Childbearing (n=6) and non-childbearing (n=4) Women

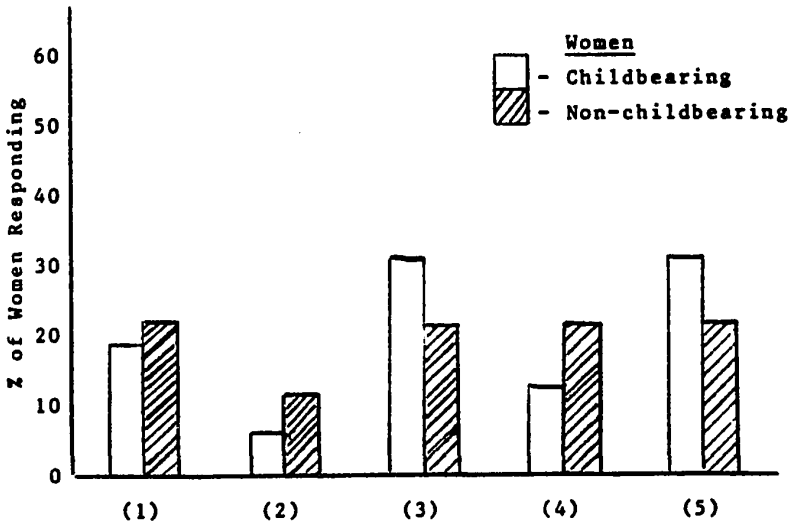
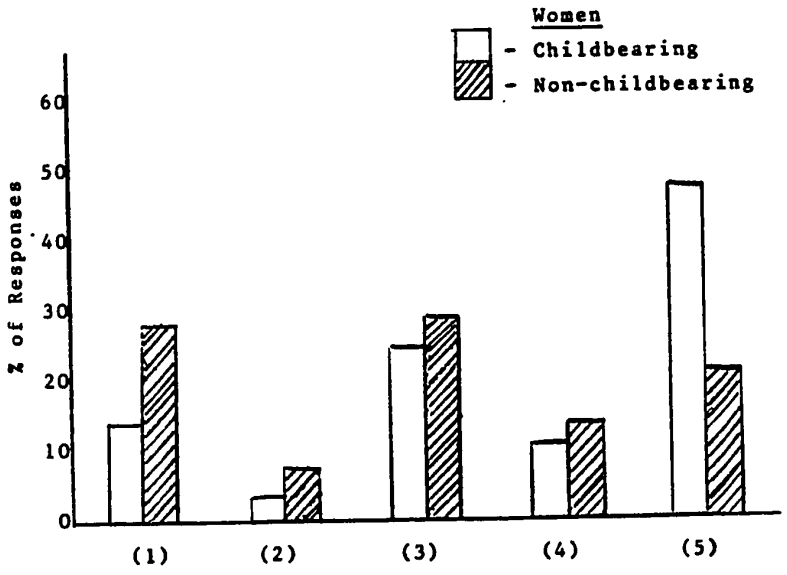


FIGURE 12

Level of Commitment to All Diet and Nutrition Teachings Childbearing (n=6) and Non-childbearing (n=4) Women



practicing them, the tendency was for them to describe the teachings in isolation to the practice (level 1) or in conjunction with an outcome (level 3). (Figure 12)

The sources of teaching were primarily the mother or mother-in-law and grandmother for the older women, while for the younger they were the mother, doctor and most frequently the woman herself - her intuition or experience. As mentioned previously, attendance at residential school required long absences from the home and reserve, changing the traditional mother - daughter relationship and interrupting the usual channels for Native education. Other female relatives such as aunts, sisters and cousins were less frequent, but still important sources of knowledge and teaching. Only one childbearing woman identified the nurse as a source of information.

"Teaching can't be turned on just like that - you have to wait for the right time "said one informant. The right time seemed to be the childbearing period, the experience. Both groups of women found that teachings were primarily, and almost exclusively, left until one was pregnant, the time of the event. Very few were incorporated into formal teachings throughout life.

The women identified the well being of the baby or fetus as the primary reason for adhering to the teachings. The reasons related to possible outcomes of physical health and characteristics of the newborn and later behaviour. Only occasionally did the teaching relate to the pregnant woman. When it did, the purpose was to suggest some change in diet because of the woman's nausea and vomiting, or cramps and aversions. The reasons for teaching the

practice varied, as did the anticipated outcomes. For instance, one should not eat crab while pregnant because:

1. of all the legs: the baby may be born with 7 toes and fingers;
2. it will make the baby soft, with soft bones;
3. the baby will have bow legs;
4. the labour would be hard;
5. baby may grow up with a "crampy" stomach;
6. baby will have jerky movements; and
7. baby will be a "biter" when nursing.

On the other hand, restriction of strawberries was unanimously agreed to because of "the mark" the baby would have.

Most of the traditional teachings admonished the necessity of restricting certain foods. No one identified foods that should be added during pregnancy. A variety of cravings and aversions was noted, ranging from Chinese noodles to alcohol. Several women noted that their tolerance for alcohol decreased, or that they had a total aversion to it; they could not even stand the smell.

The content of the teaching included fluids, seafood, meats, fruits and berries, heavy or fatty foods, Native and non-Native foods and amount of food. Some of the teachings were:

1. Fluids
   (a) drink lots of fluids, especially juice, so you won't have a dry birth;
   (b) cut down on caffiene; don't drink coffee because it will darken the skin of the baby;
   (c) do not drink pop.

2. Seafood
   (a) crab is not to be eaten;
   (b) do not eat hard shell fish - clams, crabs, mussels;
   (c) fish shouldn't be eaten as it will affect the physical appearance of the baby; it is especially important not to eat ling cod;
   (d) octopus is restricted;
   (e) if one eats the tail of the fish, the baby will come out feet first.

3. Meat
   (a) deer meat is restricted;
   (b) one shouldn't eat organ meats, such as liver.

4. Fruits and berries
   (a) berries, particularly strawberries, were believed to cause marks on the baby.

5. Heavy, fatty foods
   (a) do not eat too much fried foods or gravy - not good for pregnant women, especially as she gets bigger or she will have big baby.

6. Native and non-Native foods
   (a) should eat Indian food when pregnant - i.e. boiled fish, onions and carrots or meat with peas, onions and potatoes;
   (b) eat only natural foods, otherwise baby will be sick and jaundiced and the mother anemic;
   (c) don't eat canned or junk foods - not natural and will affect the health of the baby - "don't go the Safeway way".

7. Amount of food
   (a) don't eat too much, only eat well;
   (b) "eat just enough for the baby or the mother will always be plump".

The views on vitamin and mineral supplements differed. None of the older women even mentioned these, whereas the childbearing women who did bring the subject up were not sure whether or not they agreed with the recommendations of the health professionals. One woman stopped taking all her medications, including the prenatal vitamins, because she did not think they could all be good for the baby. Another woman was taking hers, only because she had been losing weight due to extensive nausea and vomiting. In general, additions to the diet were not identified by the women.

In summary, nutrition and diet teachings evoked a fair degree of commitment, were primarily taught by the mother,

mother-in-law or grandmother during the childbearing period and involved restrictions of seafood and berries because of their effect on the physical or behavioral characteristics of the infant. Of the specific teachings of childbearing, those related to nutrition were most frequently taught.

Teachings related to **activity and rest** were analyzed in the same way as diet and nutrition. There were certainly fewer of these teachings.

The level of commitment to the teaching showed a pattern similar to that of diet and nutrition. Childbearing women indicated a high level of commitment. Over half of these women described activity teachings that they practiced (level 5) or saw others do (level 4). Approximately a third of them noted teachings and their associated outcomes, but gave no explanation of them. Very few considered the teachings to be superstitious or conflicting with other teachings. However, no teachings, other than the Native ones, were described. Over half of the teachings described were practiced as well and one quarter of those described, associations were implicitly drawn between the practice and the outcome. (Figure 14) About 15 per cent of the activities described indicated a low level of commitment, Levels 1 and 2. (Figure 13)

The older group of women had commitment levels somewhat higher than those of diet and nutrition, but still lower than those of the childbearing women. (Figures 13 and 14) The teachings were often just told or told in conjunction with the outcome, but their opportunity for practice was gone. However, the older women did recall what they had done in the past.

The mother or mother-in-law and grandmother were the primary sources of knowledge and teachings during the childbearing period when the event was occurring. For some, the sources of some of the teachings were unknown, at least as to the specific person; while for others the woman herself was the source, again emanating from common sense or experience. No one identified health care professionals as sources of teaching.

There was a similiarity between the activity teachings for childbearing and those required throughout life. Boththe childbearing and non-childbearing women indicated that many of the teachings occurred throughout the Circle of Life and should be practiced daily. Pregnancy was not an unusual event. Modifications rather than new behavior were valued.

The pregnant woman was more frequently identifed as the expected recipient of adherence to the teaching than in diet and nutrition and was seen as the major benefiter of the teachings. Secondary gain was attributed to the baby and fetus. Most of the teachings prescribed some form of addition to activity and rest; few restrictions were taught to the women.

The content of the teaching included travel, heavy lifting and sports, usual activity of daily living including housework and child care, walking, passing through doorways and massage. Some of the teachings were:

1. Travel
   (a) it is dangerous to travel long distances during pregnancy;
   (b) a bumpy ride towards term would stimulate labor.

FIGURE 13

Level of Commitment of Women to Activity and Rest Teachings Childbearing (n=6) and Non-childbearing (n=4) Women

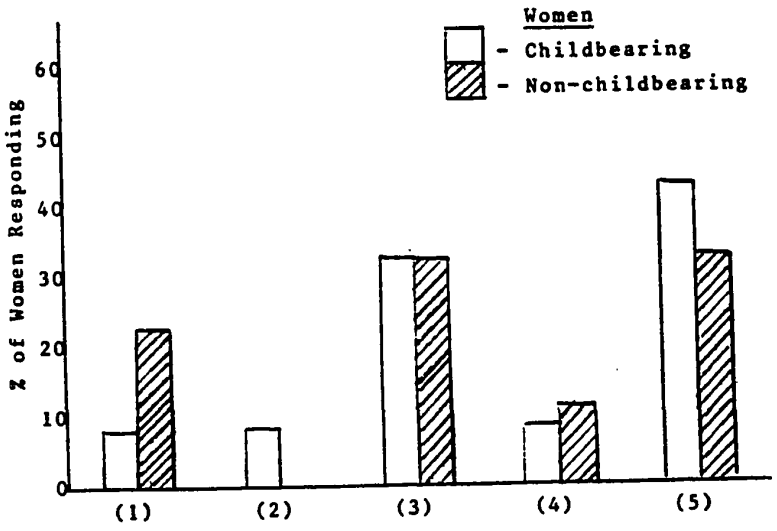
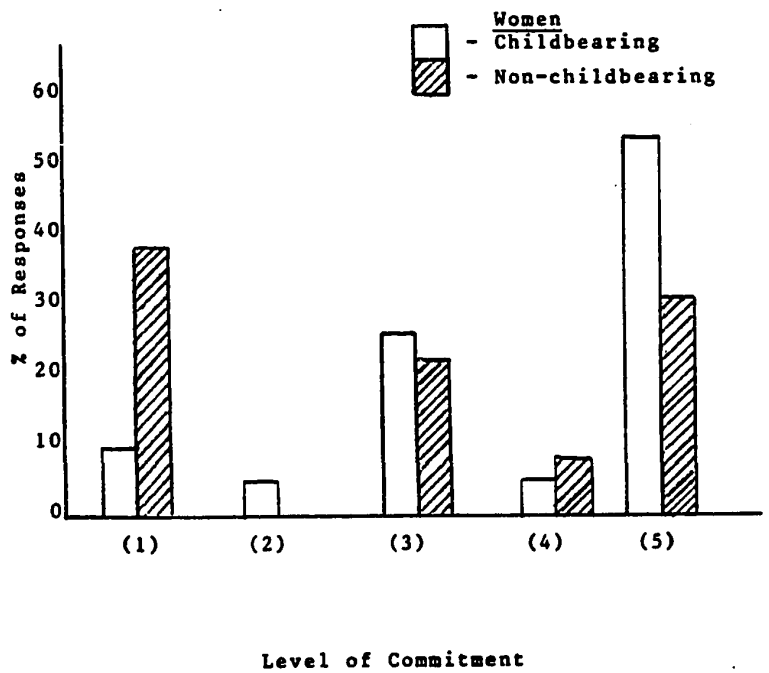


FIGURE 14

Level of Commitment to All Activity and Rest Teachings Childbearing (n=6) and Non-childbearing (n=4) Women



One mother told of her aunt taking her for a very bumpy ride around her expected date of confinement, and sure enough in a day or so she went into labor.

(c) one shouldn't have a bumpy ride in the car, as it will increase the blood loss at delivery.

2. Heavy lifting and sports

(a) don't lift anything heavy, even a large bucket of water, or you'll have a miscarriage, especially in the first part of pregnancy;

(b) if you are not feeling well, don't do heavy work and dancing;

(c) too much strenuous exercise such as heavy lifting and sports will cause too much blood at delivery;

(d) stop sports (e.g. baseball) when twisting might hurt mother or baby.

3. Activities of daily living

(a) keep active, do usual housework or work in fields berry picking.

Inactivity could cause the:

(i) baby to have a hard time during labor;

(ii) woman to have a hard, long and dry labor and a large baby;

(iii) baby to be unhealthy, lazy;

(iv) baby to be stuck to that part of the body, if the woman lies in the same position all the time.

(b) The Native woman was not to be idle. She should be knitting, weaving or sewing, for that is what the baby will learn.

4. Walking was the only type of exercise that was advised in the teachings recounted. Most of the women identified it as the means of getting into , or keeping in, good physical condition.

5. Many of the women described how hesitating in the doorway could affect the pregnancy. "You shouldn't stop in the doorway - pass right through - or else you will always be looking back and so will the baby". The baby will grow up being hesitant, without direction or alertness. It is believed that one of the ways in which this is expressed is through false labor. Sessions of false labor are thought to be the baby's hesitation of crossing over the threshold of being born.

6. Massage teachings were primarily aimed at the newborn and considered as a treatment, or means to shape her/his features. The only other time massage was mentioned was with respect to a breech birth. The midwives used to massage the stomach to get the baby to turn. Once the baby was born, it was possible to "fix" the cheeks, eyes, eyelashes and ears by massaging or rubbing the appropriate part with the fingertips.

Parents were also taught how to be alert for the protection of their babies. The father had to sleep on the floor prior to and following the pregnancy, so that he would be disciplined. If he was not a disciplined parent, he wouldn't hear the baby cry. A grandmother said that Native peoples didn't have crib deaths because they learned to be

one with the child. Mothers were taught how to get rid of sleep. Unfortunately the specific teachings were not elaborated upon by the informant, except to say that she had to open her ears to hear.

To summarize, the Activity and Rest teachings were accepted as reasonable and necessary, even if they were notpracticed by everyone. Only traditional teachings were reported and they were primarily associated with being active. Mothers and grandmothers taught these practices to make labor easier for the woman. Some practices were taught throughout life, especially from the time of puberty.

Pregnancy and childbearing is often equated by the Native peoples with labor and birth, and thus teachings about **Labour** are peripheraly relevant to this study which focusses on the prenatal period. In actual fact, however, preparation and teachings for Labor did not comprise a significant proportion of the teachings in general. The analyses was similar to that of Diet and Nutrition and Activity and Rest.

The pattern of commitment to Labor teachings was slightly different from that of Diet and Nutrition and Activity and Rest. The childbearing women tended to identify teachings of high or low commitment, and almost equal, but low, distribution through the middle range. (Figure 15) When the number of teachings identifed were analyzed, more than half the teachings were related to the higher end of the commitment continuum (levels 4 and 5). (Figure 16) However, more than one third of the teachings demonstrated no more commitment than just reiterating the content of the teaching. No thought or interpretation was given to it.

The non-childbearing women were evenly distributed at levels 1, 3 and 5 of the continuum in describing the teachings (Figure 15). However, when the actual teachings were analyzed, over half of the teachings demonstrated the highest level of commitment (level 5). (Figure 16) Each of the commitments to teaching only (level 1) or drawing an implicit association to a particular outcome (level 3) represented slightly less than one-quarter of the labor teachings.

The source of teaching varied considerably for both groups of women. Almost every source, including the family, health professionals and experience or intuition was identified. However, most frequently it was the mother or mother-in-law and grandmother. For the childbearing women experience and intuition were important sources as they did not feel that they had adequate preparation before entering labor. In only one instance was the nurse a source of knowledge in the prenatal period, as only one of the childbearing women had attended sufficient classes in the prenatal series to hear the one related to labor preparation. However, during the actual process of labor the childbearing woman remarked on how the nurses' instructions for breathing assisted their partners in helping them.

Neither the childbearing nor the non-childbearing women considered the teachings as preparation for the experience, but rather as instruction on behavior. The teachings were given in the childbearing period, close to the time of the event. Except for a couple of the teachings identifying the newborn as the benefiter of the teaching, all teachings related to the laboring woman. They primarily dealt with

FIGURE 15

Level of Commitment of Women to Labour Behavior Teachings

Childbearing (n=6) and Non-childbearing (n=4) Women

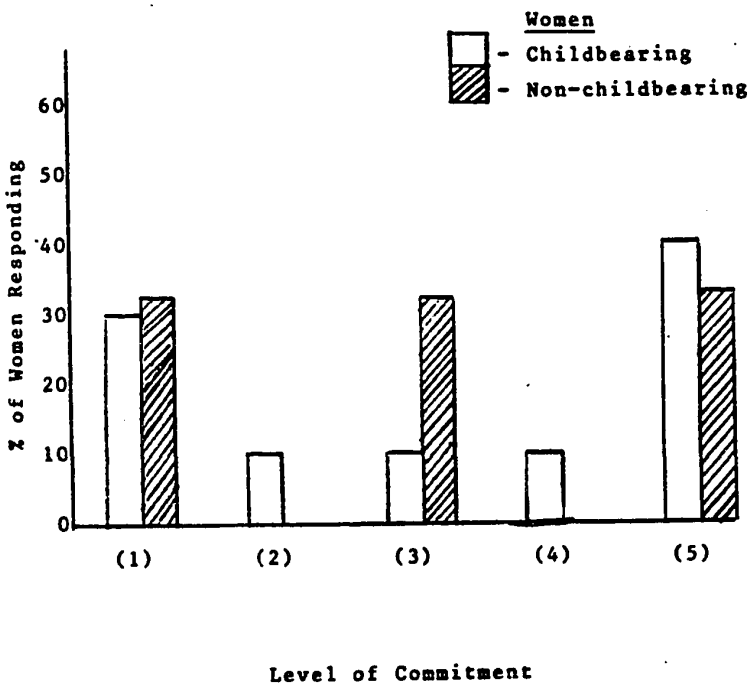
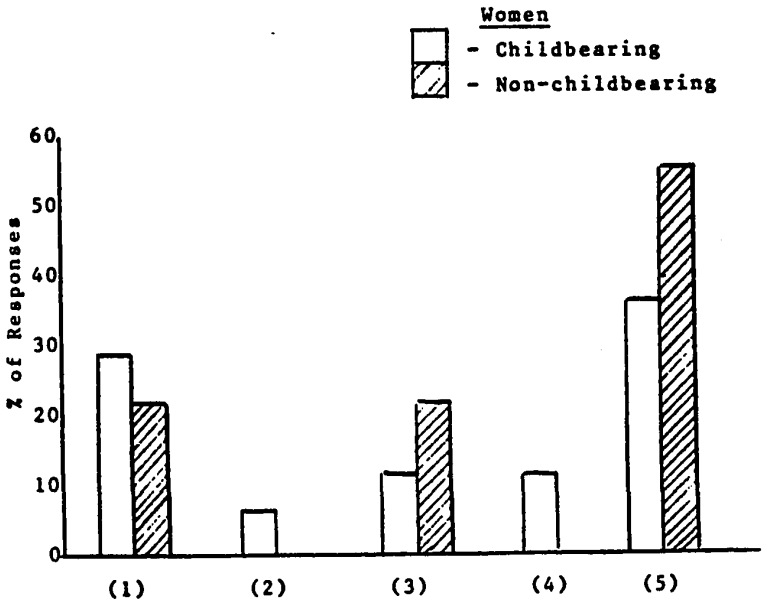


FIGURE 16

Level of Commitment to All Labour Behavior Teachings

Childbearing (n=6) and Non-childbearing (n=4) Women



personal stoicism, and secondarily to recognition of the onset of labor.

Women were taught that "it's not Indian to make a fuss: to moan and cry; be strong, don't let others know". Inevitably it was that aspect of labor that the women mentioned as being most disappointed in because they were not satisfied when their own level of adherence to the teaching, or had accepted medication to ease the pain. "I tried not to make a noise - I could hear my grandmother - the panting helped a bit." "My mother-in-law always told me not to scream in labor - the next time I won't be as noisy." Not only was it not Indian behavior, the woman felt that they lost a lot of energy when they cried out. One mother thought that was the reason they used forceps in her case, because she had cried out and wasted her energy. Two other teachings were mentioned by an elder. During labor one was to keep active by walking and move about and panting like a dog when you wanted to scream.

Neither the older nor the younger women felt at all prepared for the labor experience or how to recognize its onset. Advice from sisters, cousins and aunts given at the time of the symptoms was the deciding factor as to whether or not one was in labor, and whether or not one should go to the hospital. One mother explained it this way. "I didn't tell my daughters what it would be like - they wouldn't have gone through it if they knew what the pain was going to be like."

The older women and informants also told about teachings and stories they had learned from their grandmothers, but because they were midwife practices they did not think they

were practiced today. For an easier labor, the woman was to go to the water, find a flat, smooth rock and let it drop slowly from her hand. Another practice for easing labor was to drink daily a potion made from some kind of mashed roots and water. The father would collect the appropriate roots in the woods and prepare the drink for his daugther.

At the time of labor there were several practices that "helped with the birth". A medicine similar to the mashed roots could be given at the time of labor to help move the baby down, while at the same time the midwife helped by pushing on the abdomen. Another means of assisting the birth was to drink a raw egg mixed with olive oil. The explanation was that the woman would gag and this reflex would push against the uterus and force the baby down. Oil was rubbed over the lower back during labor to help move the baby down and the placenta away from the wall. Oil could be poured over the laboring woman's head and massaged into her head, neck and shoulders to help with relaxation. All these teachings had been practiced by one or all of the older, non-childbearing women, who experienced both home and hospital births. No childbearing woman mentioned them.

Today, essentially all births take place in the hospital. When they took place in the home in the past, the laboring woman would go out to the smoke house where preparations had been made for labor and birth. A pitch fork was driven into the ground and a blanket arranged around it. "When the time came (i.e. contractions) and you knew you were going to be sick, you'd grab the handle of the fork, hold it close to you and sway. You wouldn't make any noise.

You knew when it was the right time to kneel for the birth."

The cord was cut after the placenta was delivered and "number 10 white thread was used to tie it three inches long - you can't use black thread because of the dye". After delivery, the placenta was buried in a cloth by the husband. This had to be in a secure place, such as a hole under a rock so that it would be inaccessible to dogs. According to one informant it was especially important to do this if the baby was a girl, in order to assure her obedience to her parents. Although it is no longer possible, nor desirable, to have home births, the values surrounding labor and birth are still evident in the teachings of the Native people today.

The fourth element of the physical direction of the woman's Medicine Wheel is **Breast Feeding.** There were very few teachings mentioned; rather the women treated the subject as though it was a natural, expected occurrence and in fact all the women had breast fed their children for at least one month. It was a practice that most women felt they had had experience with by watching their mothers or relatives breast feed. When specific teachings were identifed the source was health care professionals. The nurses were identifed as an early source of teaching in the post partum period. Their teachings were described as inconsistent and at times upsetting because one conflicted with another, and the mother felt like the nurses really did not care. Occurrence of maternal or child health problems during breast feeding usually resulted in consulting the doctor about weaning.

Most women said they breast fed because it was best for the baby. Children were healthier not only as babies, but in later life. Healthier meant that they were not taken to the hospital very often. As well, "it is good to breast feed, then you don't get a family too fast", and it was "much less expensive than formula" - a concern of one of the young fathers. Early weaning in the first month occurred because the mother either thought she didn't have enough milk or it was too weak. On the other hand, many women breast fed for six months to over a year, pumping their breasts when the babies were sick, expressing milk for other's babies, and at times breast feeding another mother's baby. One mother described how she knew she was going to breast feed when she was four months pregnant because her breasts started to leak milk. She considered this a sign that she would have a good supply.

None of the childbearing women described any specific teachings about breast feeding. However, one of the older women stated that she had been told by her mother that the first milk was weak, unhealthy and not fit for the baby. The breasts were pumped until the colostrum changed to milk and in the meantime the baby was fed water from a spoon. It was also advised by the older Native women that hot towels applied to the breasts would help the milk come down, and that drinking juice and tea would increase the milk supply.

In summary, there was a high level of commitment to breast feeding; it was initiated shortly after birth for most; and it was interrrupted only for maternal or child health reasons. Early weaning was due to the mother's concerns about the quality and quantity of their milk; whereas for

most women breastfeeding extend far into the first year because it was healthier for the baby, prevented conception and was cheaper.

Clearly, the physical aspect of the women's Medicine Wheels is intimately related to that of their family through the transactional process of education. The teachings are framed around the daily family activities in child care, material and instrumental support and maintaining the physical environment. The wisdom of the family and elders is perceived by the Coast Salish peoples as being critical to the development of a healthy physical state.

East - The Power of Illumination: Strengthening Emotional Health

The Family

Emotional support was the major element of the East direction of the family's Medicine Wheel identified through content analysis. It was defined as the environment provided by the family in which feelings and concerns could be expressed and teachings practiced. Beliefs and values about maternal and fetal emotional well-being were important factors of the family Medicine Wheel and were reflected in the guidance which was provided to women during the childbearing period. Pregnancy was not considered to be a process affecting only the mother, but was very much a transactional process between the fetus and the larger environment, mediated by the mother. A balance and harmony with the larger environment, the family and community, was believed to affect the growth and development during fetal life and infancy.

The family environment was reflective of the Emotional Direction of the community and universal Medicine Wheel. School experiences, particularly those in residental schools, affected the emotional ties between the Medicine Wheels of children, their parents and reserve, and subsequently the development of loving, expressive relationships between family members, children and grandchildren was affected. Ability to "look after one's own", care for them and love them is especially important to Native peoples, not only for the immediate family members, but also fostered or adopted children. Some residential students of the past felt that the deprivation experienced in development of self-confidence and personal and cultural self-esteem seriously affected their ability to encourage these qualities in their children and grandchildren. The concerns that other Bands expressed regarding education, child welfare and health were reiterated by the Coast Salish peoples. Many of the non-childbearing women and the older informants were involved in Band activities, either as chief, councellor or speaker. The reason they gave for seeking or accepting office was to influence the way in which Band Council and the reserve members dealt with the problems of the environment that were not conducive to healthy lifestyles. They wanted to develop Native solutions to the problems of education, health and family life.

Much of the emotional support given by families was a function of "just being there - having someone around when you need them". In some instances, the childbearing woman would move into her parent's home close to the expected date of birth; others would visit among family members almost daily; while some women who lived with their

extended family were exposed to a continuous, multimember environment.

The focus of support could be interpreted as being negative or positive, depending upon the behavior that was being encouraged. If the behavior or feeling promoted the overall health of the mother or the fetus it was be considered as positive emotional support by the women. On the other hand, if the family environment decreased the feeling of well-being of the mother, or supported an unhealthy lifestyle, it was considered to be negative, especially if the woman was trying to make changes in her health-related behavior.

Positive emotionally supportive environments were described as those where the women felt their perspectives, feelings and concerns were understood by all family members, but especially by their mothers and partners, where there was a sharing of child care and family responsibilities and when assistance was not required from outside the family. It was the spontaneous invovlement of family members in times of crisis and celebration when everyone helped without being asked that provided positive support. If parents lost patience with their children, there was someone else around to pick them up, love them and find out what was wrong. The parents were not made to feel guilty about their inability to meet all the needs of their children all the time. "Just being there during times of crises" was described as important by an older mother, as she slept at the end of her daughter's bed during an emotionally upsetting time because "she just wanted me there because she was afraid of what she might do".

Family environments that might be interpreted as providing a negative quality to emotional well-being were those where the support was either for an unhealthy behavior that engendered guilt feelings in the mother if she took part, or the people expected to provide the support were unable to do so. In the first instance, encouragement by the partner to go out drinking was considered negative. If the woman did go out with him and drink, she frequently described feeling guilty about doing so because she felt it was not good for the baby. If she did not go out with him, and he went off on his own, she was left home alone. The women described experiencing feelings of anger, isolation and frustration that their partner could do that to them.

The second form of a negative environment emanated from ignorance, fear or lack of awareness on the part of significant family members. Mothers or mothers-in-law that were too scared to accompany the woman into the hospital, or partners who "did not have enough nerve" or see the need to attend prenatal classes decreased the women's feelings of emotional well-being. The women felt they had to cope with the situation on their own, or in the event of prenatal classes they often decided not to attend.

Family emotional support was seen as second in importance to material or instrumental aid. It was perceived as being primarily of a positive quality, but the negative aspects were recognized as well. The mobilization of emotional support was most often of a spontaneous nature, given without asking or offering. Reasons for doing so included: visiting because of a cultural or family event or because passing through on travels, involvement because it was a family matter (e.g. death, accident airsickness), and being

part of the family. For the childbearing women, the most relevant reason for support was because of labor and birth.

The Woman

The Medicine Wheel of the childbearing woman includes her feelings and emotions, the ways in which she made decisions and how she defines the event of childbearing. These elements comprise the East Direction, one of illumination and new life. In each of the elements, family teachings and expectations were identifed and analyzed. Those addressing emotions and feelings were analyzed according to the categories used in Education, Diet and Nutrition and Activity and Rest. Specific categories for decision making and definition of the event were defined during content analysis.

Teachings about emotional well-being were directed towards the mother's state of mind and feelings since it was believed that they had a strong influence on fetal and these teachings was very high for the woman (Figure 17), and shared trends similar to the other three categories of teachings. The childbearing women showed a particularly strong commitment, with almost two-thirds practicing the teachings (level 5). Very few indicated a low commitment.

No childbearing woman considered the teachings to be superstitious or to conflict with other teachings. One quarter of them either noted others practicing the teachings or associated the outcome with the teaching in an implicit manner. A similar degree of commitment was evident when the total number of teachings was analyzed

(Figure 18). The distribution was congruent with the individual woman's levels of commitment.

The degree of commitment for the non-childbearing older women was equally distributed among the three higher levels (Figure 17). However, when the teachings were analyzed, these women showed a greater commitment to the highest level, indicating that they had practiced it themselves. (Figure 18) These teachings seem to have made a lasting impression on the older women and were not readily forgotten. Like the childbearing women, no one considered the teachings to have any element of superstition. The beliefs were valued and reportedly practiced quite faithfully.

The sources of knowledge were varied for both groups of women, but were, on the whole, family members. Unlike the other teachings however, mothers, mothers-in-law and grandmothers were no more frequent a source than aunts, sisters and elders. One childbearing woman referred to a book written by members of another Coast Salish band. Health care professionals were not an identified source.

Once again education occurred during the childbearing period, or very near the time of the event such as labor. Because the teachings are consistent with the Native philosophy of life, several women remarked that they were prepared for the teachings throughout life and now they were just learning the specific requirements related to childbearing.

The only expected recipient of adherence to the teaching was the fetus and child. Teachings contained both

additions and restrictions. The additions comprised positive feelings, happiness and calmness; while restrictions were made to sensing, in any way, anything unpleasant or powerful.

Most of the teachings related to thoughts about the fetus and one's state of personal feelings. To a lesser extent the teachings dealt with personal experiences and observances. It is believed that whether or not one wants to be pregnant will not only affect the emotional well-being of the fetus, but the state of physical health as well. A woman who did not "treasure her pregnancy" now recognizes that there is something different in her relationship with that child compared to her others: "the relationship with my daughter shows". The baby is believed to know when it is not wanted, especially when the mother attempts to get rid of the pregnancy. Not wanting the pregnancy or thinking bad thoughts was also related to outcomes such as still births, crib deaths, or "something" would happen to the fetus or baby. What is thought and done can also affect one's ability to conceive. One mother told of being off birth control for three months before becoming pregnant. It was her husband's desire, not hers, to have a child at that time. She stated "I didn't want to become pregnant. I really believe that what you think can affect your body - I think that had a lot to do with it (the ability to conceive)".

Not only is the woman's body and the fetus influenced by thoughts about pregnancy, but by her general emotional state as well. If she is tired, on edge or anxious, the fetus is likely to show some kind of response. In one instance the baby reacted to the mother's emotional state

FIGURE 17

Level of Commitment of Women to Emotional State Teachings Childbearing (n=6) and Non-childbearing (n=4) Women

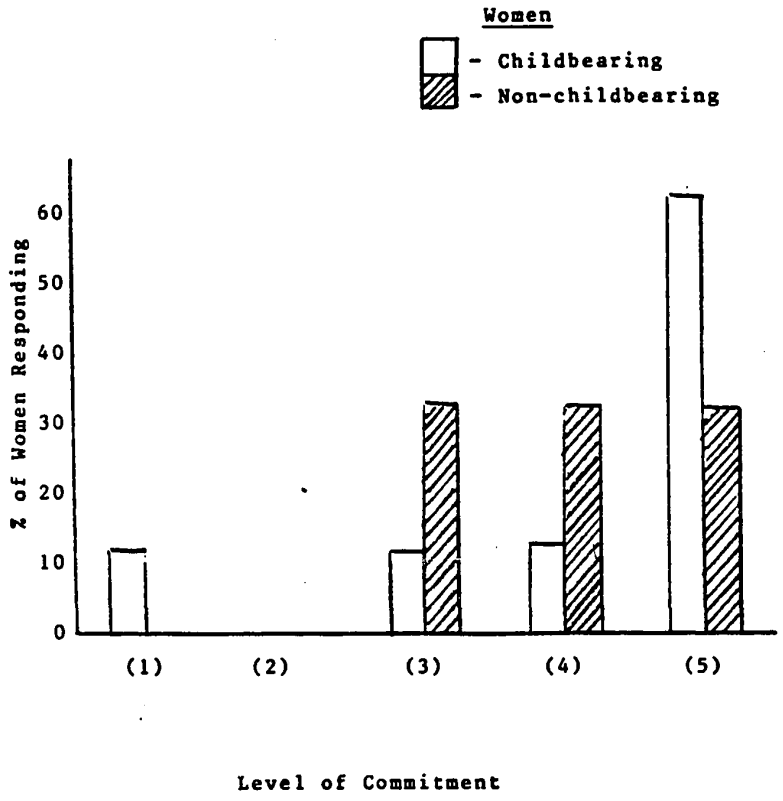
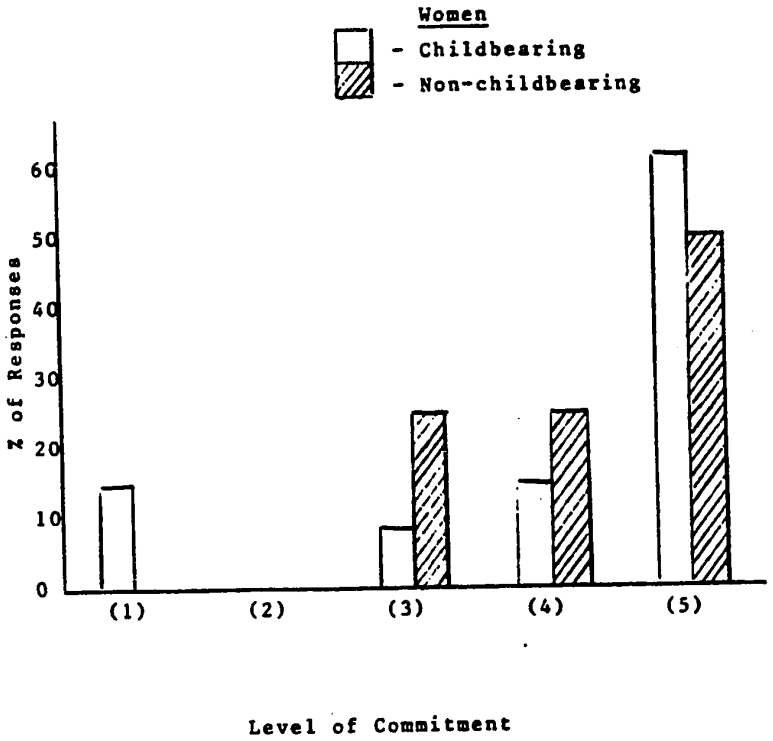


FIGURE 18

Level of Commitment to All Emotional State Teachings Childbearing (n=6) and Non-childbearing (n=4) Women



by "coming a week early". Other responses are a direct reflection of the mother's emotional state. If she is mad or angry, the baby is likely to have a bad temper. Feeling upset or guilty and lacking self-esteem were believed to upset the fetus in utero or the infant that was being breast fed. It was also believed to be important to share feelings so that the child would not grow up "harsh". As one mother described her situation: "My mother-in-law watched my mental attitude; she didn't want cranky granddaughters". The advice given is to "speak softly and with pleasure - for what you are so also is your child".

A mother's experiences were also thought to influence the health of the fetus. Pregnant mothers were cautioned against attending funerals, looking after dead bodies or caring for sick or handicapped persons for fear that the baby would develop the problem(s) or characteristic(s) of those individuals. Similar to this belief is the one associated with viewing certain animals or frightening and strange objects or people. The mother was not to look at anything strange or frightening, e.g. horror movies or television shows since the baby might be born that way. If the mother did see something that was frightening or ugly she was to spit. On the other hand, if she saw something pretty or pleasant she should swallow. The Coast Salish belief is that the baby's and the mother's senses are one and the same. Therefore when the mother spits she gets rid of the internal ugliness; when she swallows she supplies her baby's senses with the same external experiences. What the woman sees and feels will be transferred to the fetus and affect her/his emotions afterwards.

In summary, the maternal and fetal environment was described as being important to the healthy development of the fetus. In order to provide a happy, safe environment for her child, it was thought that women should not be confronted in ways that would hurt her feelings. Her partner is expected to create a comfortable and worry free environment. Not surprisingly, there was great variation in the extent to which these teachings were put into practice.

Closely associated with the teachings of emotional well-being were the women's approaches to decision making and definition of the childbearing event. **Decision-making** included the actual decision to become or not to become pregnant, the skills the women identified as being used to make the decision and personal characteristics noted as being important to the process.

In the majority of instances for both the childbearing and non-childbearing women, they had made a decision to become pregnant. The major reason for deciding not to become pregnant was for financial reasons, while the decison leading to pregnancy was based on the importance of a child to the Native family or resolving family differences. Another less frequent, but very important, reason for not becoming pregnant was marital status. Pregnancy among Native women who are not married, either in the Native or legal sense, was seen as undesirable by the Songhees families: a situation that would lead to shame on the family. The women had not left the conception decision to chance, although several described the decision as being their partner's rather than their own. This is important

in view of the emphasis placed on the impact of maternal feelings on conception and fetal well-being.

The childbearing women relied primarily on life skills for making the decision: personal attributes that they had developed for themselves. Secondly, they used communication skills to negotiate or discuss the event with their partner. For the most part they considered the decision one which they had singularly made. Very seldom did they consult with other family members or friends, i.e. they did not have to mobilize support or service to assist with the decision. The non-childbearing women referred to the advice and input of others, especially mothers and grandmothers, when making the decision regarding pregnancy more frequently than the childbearing women. However, one's own life skills and communication with one's partners were more salient to the decision-making process than the mobilization of support.

The personal characteristics that influenced the decision-making process were either implied in conversation or observed in behavior. Assertiveness and feeling in control were the most positive characteristics identified by all women, but significantly more salient to the childbearing women. Assertiveness was evidenced in being able to state one's own opinion, reject advice when it conflicted with one's own value system and seek out helpful resources as required. Of equal importance to the older women was the characteristic of being hesitant, unsure of oneself and reticent to state an opinion. Childbearing women also identified this characteristic as a concern, but to a some what lesser degree. Nonetheless, it was evident among both groups of women.

Only the childbearing women indicated that their decision making was associated with learning from others. They then tried to incorporate this ability into their own personal character. Learning from others was often related to the facts or knowledge one required in order to make an informal decision. Family members were the most usual source of information, with options and consequences outlined, but definitive advice withheld.

> We were always given a choice by mother - weren't told you had to do a particular thing. We were given options and the consequences were pointed out, with clear indications that it was best to do one of the things, but that was your

choice stated a respected and wise elder.

It is interesting to note that this family orientation to decisionmaking differs from that of the Band where it is often felt that the counsellors and elders make decisions for the members - decisions which are not always well received. The element of choice in that situation has been removed. If this is a change to the traditional Band decision-making process, it will be important to note if, and when, it is reflected in the family's decision-making process.

When advice was sought from doctors, the information was treated in a similar manner. The women still considered the choice to be theirs, but stated that this posed quite a dilemma when they knew, in the long run, they might not have control, especially at the time of labor and birth and they felt they had no choice in changing doctors, as only a few were recommended as being sensitive to the Native ways.

The category **Definition of the Event** included knowledge of conception, suspicion and confirmation of pregnancy and reaction to the event. Without exception the Coast Salish women were knowledgeable about conception, but were less so regarding the means of preventing it. Suspicion of pregnancy was related to the probable signs: missed period, breast changes, fatigue and occasionally nausea and vomiting. Several of the childbearing women attempted to confirm their suspicions through self-administered pregnancy tests; others eventually went to the doctor either because they thought they were pregnant but continued to have their period, or were having other health problems. Neither childbearing nor non-childbearing women considered it essential to have a health professional confirm their pregnancy if everything was normal.

On the whole both personal and family reactions to the pregnancy were positive, and in some cases described as ecstatic. If a negative response was noted initially, the women stated that it did not last, although it was upsetting at the time. The negative response was generally related to the timing of the event, i.e. it interfered with some immediate plans. An initial response of indifference and confusion were frequently noted on the parts of the mother, her partner and her family. It seems that an adjustment time is required for the significance of the event to take hold, because by the middle or end of pregnancy these feelings had usually changed. However, it is important to recognize the impact this has on the provision of a comfortable, worry-free, emotionally supportive environment advocated by traditional beliefs and values.

Strengthening the emotional health of mothers to ensure fetal well-being is a significant function of the family environment. It does this through explaining to mothers how to improve or maintain their emotions, feelings and concerns and informing those in immediate relationships of the requirements for a comfortable and worry-free environment. The power of illumination is fostered through family mediation according to the Native way of life.

South - The Power of Innocence and Trust, Encouraging Socio-Cultural Health

The Family

The South direction of the Medicine Wheel is concerned with socio-cultural health. It finds its strength in the power of trust and freedom from evil and sin. The family's Medicine Wheel in the South, like that of the north and east is a microcosm of the universal Coast Salish Medicine Wheel.

The functioning of the family might be likened to that of a mediator or culture-broker: an intermediary between the Songhees community and the individual: a force that influences both the transmission of social and cultural beliefs and values and the acquisition of lifestyle behaviors. As a mediating structure, the family gives stability to the individual.

Family relationships and support were determined through content analysis to be the most meaningful forces of mediation. The type and quality of relationships that exist between family members within and across generations and

the characteristics of the extended family were identified as subcategories in the analysis. A feeling of belongingness, social interaction and integration and a sense of mutual obligation defined the category of support.

Teaching respect was the single, most important quality of **Family Relationships** identified. Respect was required across generations, with the younger showing respect to elders for their age, wisdom and experience. Parents taught their children to respect them and other adults as sources of teaching and discipline. Adopted children were taught to respect both their legal and foster parents.

> They are to think of us (foster parents) as their mother and father as long as they are with us. They become part of us as long as they wish, but they always have the right to go back. They have the choice to be in the family they wish. That is why they need to be taught to respect both.

The whole community was at one time considered responsible for making sure children and adolescents behaved in socially and culturally acceptable ways. Although this is less prevalent today, certainly all adult relatives are expected to participate in the parenting of the children in their extended family. Spouses are expected to be open and sharing in their communication. The Coast Salish word for spouse means "a person you are one with". To do this,respect must be present and trust built up. Respect for in-laws was expected, just as it was for one's own parents.

Respect is also built on pride. It was evident that much pride was generated through one's ancestors. The exception to this occurred when there was a history of alcohol abuse

with accompanying family violence. Most frequently it was the father who had the problem and although the family may not have separated, the situation was at times seen as almost destroying the family. The wives in these families were reported as having remained in the relationship because there was nothing else to do. In many instances however, it cost them their respect for their husband and at times a loss of self-respect.

In a culture where self-respect and respect for others is so highly valued, showing disrepsect could result in considerable family stress. How one acts is believed to reflect on one's family. If the member does not follow the rules and disciplines, people ask "don't you teach them anything?" Making mistakes costs the family money. Family stress under these circumstances was seen as disjunctive, rather than encouraging cohesiveness. The same was true of those situations where children were sent to residential schools. Disjunctive family relationships impaired the family's ability to mediate between the Coast Salish cultural values and beliefs and the individiual's ethnic identity and self-concept. Expected behaviors in ceremonies, rituals, arts and games were said to be lacking in individuals because their family had been unable to teach them. At the same time however, they had readily available role models for lifestyle behaviors that had the potential for causing further family stress and cultural erosion. Families were described as "poor" by the Native peoples when they had neither a strong orientation to, or knowledge of,their family geneology and Native heritage.

Both childbearing and non-childbearing women identified parents, siblings and their partners as the most signifi-

cant family members with whom they had important daily relationships. The sibling relationship among sisters was identified more frequently by the childbearing than the non-childbearing women. Although not as frequently mentioned as the aforementioned relationships, the mother-daughter one was also important. Less emphasis was put on the relationship with extended family members.

When the data were analyzed a variety of reasons were noted for the importance of the family relationship. The most prominent one evolved around child care. This included holding, playing, caring for and babysitting, and was generally related to immediate household members. The means of maintaining relationships with extended family members living outside the household was visiting. This was identified as a very important activity and one which was initiated by the younger generation more frequently than by the older one. A first outing for new parents and their baby was most often to grandparents. This was expected by the grandparents to occur within hours, if not days, after returning from the hospital, even though a two hour drive one way might be required. Other less frequent reasons for the relationships included teaching-learning and marriage.

On the whole, the characteristics of the social ties, from the Native people's perspective, were positive. Both groups of women described negative, non-supportive characteristics primarily related to the use of alcohol or relationships with parents-in-law. Fathers who drank heavily were disruptive and often described as ugly or abusive to the family when they were inebriated. Today, some parents also look at their own drinking behavior and

think "I guess our kids don't have much respect for us when they see us drinking". Heavy drinking by other family members such as sisters and brothers have also caused family disjunction.

It was customary after marriage for the couple to liveon the husband's reserve, if not with his family. For some women, living with their parents-in-law was stressful, as they did not know either the cultural ways of that reserve, or the family life and expectations. They may not have been able to understand the language either. As one older woman said "Our marriage improved when we moved out on our own - I was always so nervous with my mother-in-law - but I tried to learn". If not living with the partner's family there were expectations that close helping relationships would be maintained and when these precluded relationships with her own family or friends, the woman viewed the relationship as non-supportive.

Another source of negativity was disapproval by one's parents of one's chosen partner. The disapproval has been due to differences in age, family background and ethnicity. Older men, males from different reserves and non-Native partners resulted in disapproval by several parents and in one case where the woman decided to go ahead with her decision, her mother did not attend the wedding.

Inseparable from Family Relations, was the second category of family socio-cultural health: **support.** The positive characteristics of family ties related to maintaining family cohesiveness, supporting the family name and providing a mutually supportive relationship. Children and grandchildren were undoubtedly the most powerful force in

developing cohesiveness. Living with extended family members, visiting frequently and celebrating birthdays as family events were also means of retaining family cohesion. Providing a sense of belonging to children was readily observed in family behavior. They were hugged, kissed and picked up. This was especially true of the infants. Older children in some families got special attention from their fathers as they were sung to sleep with Native songs.

Support of the family name was observed in the proud references made to family accomplishments and power, inner spirit and memorial ceremonies given to honor dead relatives. The Coast Salish peoples placed great emphasis on learning about one's relatives, who they are and how they are related. This not only defines family, but indicates who is available for marriage. Anyone closer than second cousin is considered family and not eligible for marital relationships.

Not only are families able to physically accomodate relatives requiring shelter, "we always have enough love", they are taken into the family and expected to contribute to its life as long as they stay. A mutual give and take relationship is expected. Children are kept around as long as possible and elders tend to be cared for either in their own homes or in the homes of their children by their children. Both childbearing and non-childbearing women stated that they had received support from their families to return to school for upgrading or specific training, or were supportive of their daughters in doing so.

The Woman

Health beliefs and practices, teachings about menarche and lifestyle behaviors of smoking and drinking are elements of the woman's Medicine Wheel in the south direction. They reflect values, beliefs and practices of the family with respect to socio-cultural well-being. Because menarche is a time of rebirth, a time of learning a new role and an opportunity to develop one's self concept, it is included in this direction. Health is also a relevant element because of its social definition and cultural interpretation. Role models and teachings in the family environment are associated with the woman's lifestyle habits regarding smoking and alcohol consumption. Each of these elements contributes to, and is influenced by, the woman's self-concept. Each is important to the understanding of childbearing beliefs, values and practices.

Health includes the teachings and definitions of health in general, as well as a preliminary analysis of the health seeking process, including explanatory models identified, health care sectors used, problem or concern and the logic of beliefs expressed. The Coast Salish peoples on south Vancouver Island tended to view health in ways similar to other Native peoples. They expressed a holistic perspective of health as emotions were considered to affect physical needs and both types of needs were influenced by social and family needs. The result of this interaction was something called "health". It was expressed by a Coast Salish mother:

> They (elders) say that if you mourn and hang onto problems - your problems, childrens problems, social problems, emotional problems, - whatever it is - don't hang onto it too long - you're

> asking for trouble - you'll have debt - you do not want your health problem to continue.

Another person related health to the disciplines: "The disciplines must include mind, body, soul and emotion - one can't develop without the other". A healthy person has to pay attention to physical, emotional and spiritual aspects of herself or himself. Self respect, a good mind and a community orientation were considered to be fundamental to good health. Health for many was equated with the ability to cope and to endure, to be strong and alert and to have energy. There was a belief stated that if one "listened" to one's body, it would indicate what was good and not good for it or the baby, such as cigarette smoking, playing sports or drinking alcohol during pregnancy. The mind would be "turned off" the cigarettes or alcohol because of the body's response.

Means of promoting and maintaining this strength and energy was conditional upon sharing one's problems, as well as preparing oneself through disciplines and purifications; for instance, when bathing in streams or rivers, a means of attaining strength, one had to be mentally, physically and spiritually prepared. Mental preparation meant making up your mind that you were going to do it - "like making up your mind to do a certain piece of work". To be physically prepared it was important to bathe by going in slowly and steadily, immersing one's self four times with pauses between each immersion. The pause allowed the feeling to go through the body and the mind to appreciate that feeling. Praying while bathing was the spiritual preparation required. The outcome was experienced as a revitalization - a feeling of renewed energy and spirit, "sinuit".

While health was a positive force, related to all directions of the Medicine Wheel, illness or sickness was viewed as "a power of negativity" and referred to as "a pain" or "hardship". There is the belief among some of the Coast Salish peoples that everyone is wounded or sick in some way and therefore everyone requires healing in some way. Everyone needs to be challenged to grow, each in his own way. Pain and "sorrow in your heart" become a "burden in your mind" which lead to sypmtoms in the physical self, such as stomach problems. Relief of pain and sorrow is thought to be brought about by disciplines and activity. It was believed that laziness brought on hardships because it allowed the individual too much time to "work things over in the mind" and resulted in a lack of proper perspective. To shed sorrow and pain, physical training, as well as mental, emotional and spiritual training were important. These trainings varied with the different times of the Circle of Life. One Coast Salish man also described how his grandparents used a brushing motion down the body to get rid of sorrow and physical illness; while a female elder spoke of her father's practices of massage when healing her children's illnesses. Sharing problems in a communal way meant that "if you were mourning, you talked out your cry. You went to the beach. When you finished people would bring you water to wash your face and replace your tears". To keep mourning, sorrow and pain inside oneself was believed to bring on more problems. However, learning to share this in a healthy, growing way, was apparently difficult for many Coast Salish peoples and they still had to learn, through their experiences, to do so.

Although the Songhees peoples deny the current existence of a Shaman, or Indian doctor, on their reserve, it is

believed that one lives on the island. Some believe that the reason the Indian doctors have died out is that those who might have the power, the "sinuit" today, do not acknowledge it or question the development of it because they do not want the responsibility that goes along with it; they fear its potential power or the fact that it is considered to be malpractice, if not illegal practice in Canada. In the past, some Shaman's medicine were of a "good nature" and did good things, but others had medicine powers that could cause illness. Today, much of the Native healing that takes place outside the family is through the Shaker Church. The "shakes" are a non-invasive form a healing when the spirits of the helpers and healers are in touch with that of the sick person and a form of theraputic touch is practiced. It is believed that prayers and feeling wanted and loved are critical to the healing process.

During the interviews and numerous telephone calls during the study there was considerable exchange regarding illnesses of family members or of the woman. This was most evident among the older non-childbearing women. There was a great deal of discussion about symptoms, the majority of which were defined in physical terms, although frequently neither proper anatomical nor physiological terms were used. When describing a symptom related to a "sensitive topic", such as menopause, slang terms or euphemisms were used. Recognition of symptoms seldom resulted in a modification of, or shift, in role expectations. The more usual behavior was to selftreat and then to seek consultation. For the most part consultation was with a family member first, then to a traditional healer. Physicians were the third source of consultation,

frequently in conjunction with or after the traditional healer. Neither the Community Health Representative nor the Community Health Nurse were viewed as consultants, unless they initiated the contact.

According to the women, the treatment regimen of the Native healer or family was usually followed, including taking Indian medicine if it was available; while adherence to Western treatment regimines varied, especially with the taking of medications. If the illness was perceived by the Native person to be due in part, if not wholly, to Native problems and explained in Native ways, consulting a non-Native physician and following her/his treatment was not seen as meaningful. Some of the concerns thought not to be understood by the non-Native medical care system are Native family and foster care problems - the emotional and social problems. "The doctors don't see anything wrong with my brother, - I do - I could tell you lots of evil things". On the other hand if faith had been put in the physician but the treatment was not all that was anticipated, Native healing gained importance and, in a way, was described as being more powerful than its Western counterpart.

The health problems described by the women were extremely varied, but primarily included physical and developmental concerns. The only suggestion of an emotional problem was eluded to as a "Native problem" - a cultural problem, but the symptoms were not expanded upon. The major physical and developmental problems were stroke and paralysis, flu and cold, accidents and infections.

The four categories of logic: invasion, degeneration, mechanical and balance were included in the women's explanatory models of the illnesses. Several described a spiritual/emotional category as an influence on the future of the self or the child, if the woman was pregnant. Although not as frequently referred to, over half of the women explained at least one illness in terms of a spiritual or emotional cause and effect. The form of logic most prevalent was that of balance: maintenance of harmony in one's environment and relationships. The germ theory, logic of invasion, was often combined with the logic of degeneration, becoming run down. The two together might also be viewed as logic of balance and harmony.

Thus, the Native Coast Salish perspective on well-being and illness, health and sickness, was very much determined by both the social and cultural environment. Their health seeking processes and explanatory models, although incorporating some western concepts, were essentially Native based: a perspective of considerable consequence to understanding childbearing practices and the seeking of perinatal and infant care.

The teachings about **Menarche** were coded similiar to the childbearing teachings. Menarche is considered a special or sacred time in the Circle of Life. The time of coming into womanhood is a time of rebirth, and blessing, and thus requires training. Grandparents and parents were, and still are, responsible to see that this training is done, even though it is hard on the young girls. In general, according to many older Coast Salish adults, it was a time of confinement and lectures. The young girl was separated from the rest of her family, restricted in the amount and

type of food she could eat and with whom she could play and talk. Because womanhood was a new role and these teachings were not yet a part of the girl's purification, meditation and close observation were required. However, what seems to be lacking in these teachings are references to physiological changes to be anticipated. The emphasis was on preparation for the social and cultural expectations of womanhood. This was similar to the childbearing teachings.

The childbearing and non-childbearing women who described menarche teachings also described a high level of commitment. All these women practiced the teaching (level 5) and most quickly pointed that it was because their mothers or grandmothers were watching over them. The teachings took place at puberty, usually just prior to the time the first menses was expected and continued for varying lengths of time, but at least one month. The only expected recipient, at the time of the teachings, was the pubescent girl, but in the long run it would be her husband and children as the preparation was intended for the future roles of wife and mother: habits that were meant to continue throughout life.

The content of the teachings and disciplines revolved around five major themes: activity, hygiene, diet and nutrition, role of woman and role of wife. With respect to activity, early rising, keeping busy and helping with the housework were emphasized, otherwise the girl would grow up lazy and not know how to behave. The women recounted their chores of fetching water, scrubbing floors, doing laundry and having to get up earlier than others to go to the river to bathe. Today, one activity that is often restricted is television watching as it leads to laziness.

Cleanliness and hygiene teachings were expected to be practiced "during this time every month." If one did not learn how to take proper care of oneself at this time, one would be unclean the rest of one's life. The specific teachings were not identified and no explicit reference was made to the body's anatomy and physiology, or the supplies women required.

Similarly, nutrition teachings were spoken of in a general way. For some women, menarche and menstruation were considered to be such special, sacred times that they were not even supposed to prepare foods, especially the salmon. For others, it was a time of eating right, not too much fat or water, as that would make them slow moving and sluggish.

Particularly important to becoming a woman was giving up the ways of youth. This meant no longer playing with boys, not laughing a lot and talking only when there was something important to say. The role of the woman required "acting like a lady", knitting and beading, listening to and learning from older women and working hard.

Learning to be a good wife was linked to learning the role of a woman. For the older women, it also meant learning how "to look after your man". Specifically what this meant was not clear, except that it included knowing how to wash, mend and cook.

Thus, the content and intent of the teachings at puberty were very much related to lifestyle behaviours and values that would be important throughout the Circle of Life, as well as during the childbearing period. Teachings about the actual process of menarche, as was true with pregnancy,

were almost non-existent. Information and knowledge came from one's own experience or older sisters and cousins.

The women's lifestyle behaviours of **smoking** and **drinking** tend to be similar to those of their families. The smoking practices were varied for both sexes. In homes where it was usual for men and women to smoke, it was not unusual to find the women smoking. Approximately one-third of the women in the sample smoked, at least occasionally. Three women said that in their grandmothers time it was not acceptable for women to smoke cigarettes, but maybe a pipe. There were no identified teachings about smoking in the childbearing period. However, most of the women who smoked stated that they had stopped when they were pregnant and one also tried to get her partner to stop. The reasons given were a bodily reaction to smoking or smoke and "knowing it wasn't good for the baby". The source of information could not be identified, but it was not from a health care professional. One of the Coast Salish men felt that it was only common sense not to smoke during pregancy.

The lifestyle practices around alcohol consumption were more difficult to analyze. Not only were they varied, but for the childbearing women, talking about drinking during pregnancy brought out feelings of anxiety and guilt. Patterns between families and the women appeared similar to that of smoking. In most families drinking was the norm, although the amount and frequency varied. A usual practice was to drink with one's spouse, relatives and friends. Special family occasions such as birthdays, weddings and holidays were generally noted to include a heavy amount of drinking. Everyone was expected to share in consuming the

alcohol, just as they were expected to share the food. To do less would be disrespectful to the host.

For some individuals for whom drinking became a problem because of the effect it had on family relationships and children, there was a pattern of development. Experimentation with alcohol in the early or mid-teens progressed from one night of drinking on the week-end to two nights. This was followed by drinking increasingly greater quantities with week-end events progressing to mid-week ones. Late afternoon to late night drinking changed to early afternoon to morning bouts. Eventually two week binges became a norm. The purpose of drinking was to get drunk. For some this meant making arrangements for their children to be looked after on the week-end because they planned to do heavy drinking. Under these circumstances, amounts consumed are unknown. The pattern of drinking just described most often occurred in a home rather a public facility.

More social drinking in the public places, especially in beer parlours, occurs frequently. Families or friends may go as a group. It is a place to socialize and have fun. Many of the childbearing women described this pattern particularly in reference to changing their drinking habits during pregnancy. It they were not going to drink, then they either did not want to go to the beer parlour, or they were not welcomed by their partners and friends if they were not going to drink. However, for the majority they did not go because they did not want to be faced with the opportunity of drinking and being exposed to their friends doing so.

Many of the women stated that they had not been drinking, at least drinking heavily, during their pregnancy. The reasons given were: they had not started to drink until they were older and were no longer having children, their body had reacted to the alcohol and they could not take it even though they wanted to drink or they had heard or known it was not good for the baby. Knowledge of the source of this information was vague. Some thought that in the past, Native women were not supposed to drink - therefore it could not be good during pregnancy; for others it was intuition or common sense; and for a few, they had heard that it could affect the baby. What these effects on the baby might be were not known. The women who believed the baby could be affected and drank on occasion during their pregnancy described feeling guilty and bad that they were going to be terrible mothers. The occasions for drinking were related to family social events and being separated from one's partner when he was out with friends drinking. The main reasons given for not stopping during pregnancy was the comparison of oneself to another who drank during pregancy with no adverse outcomes noted.

Other reasons for attempting to stop or reduce drinking included family problems (influence on children, family violence, deteriorating marital relationships), and cultural events (initiation or participation in the Longhouse, joining the Shaker Church, pulling in canoe races). Discussion of alcohol brought forth many values of drinking. It was seen as the cause of many problems, especially with the family, as well as the means of relieving problems. Apathy, lack of self-respect, and guilt were identified as emotional problems of some seriousness. Several of the women described how they hated

to see other Native women drinking - in some way it reflected on their own self-concept. They made no such reference to seeing Native males under similar circumstances.

Thus, the woman's lifestyle beliefs, values and practices that begin at puberty or before and carry on throughout the Circle of Life are almost inseparable from those of her family. The socio-cultural environment that the family creates and that is influenced by the community and the woman herself provides another opportunity for women to develop an ethnic identity and a self-concept, both of which influence the practices in childbearing.

West - Power of Introspection: Spiritual Fulfillment

The Family

Spirituality has been defined by the Coast Salish peoples as being the core of their existence: the essence of life. Yet it is the most difficult to enunciate. It includes Native Band religious affiliations and behaviors as well as sacred beliefs and practices of families. Spirituality is communal and it is personal. It gives substance to both group ethnic identity and individual selfconcept. The family, in its transactions with both the community and member, was found to have the potential of supporting a band orientation to spirituality rather than materiality and an individual pursuit of inner strength and power rather than apathy, self-effacement and self-abasement.

The family's spiritual direction of its Medicine Wheel included, at the minimum, family values, Native lifestyle

practices and healing responsibilities. Although the obvious behaviors were available data for analysis, it was clear that family beliefs, values and special practices were inviolable traditions. Elaboration of sacred teachings was inconceivable, even to other Coast Salish peoples.

> Some of the things in our culture are very sacred to us and the practices of these beliefs are very important to us. They are sacred because the general public doesn't see them. So there is a part of our culture that is known only to us.

Thus, what is reported here is only part of family spirituality. In respect and honor of the families whose members shared as much as they felt was acceptable, no examples or specific incidences are included.

The relationship between the family and reserve was clearly a two-way interaction. Influences of the teachings and experiences of the Longhouse and Shaker Church were evident in family life. Winter ceremonial dancing and summer canoe racing lent direction to family movements on the week-ends. Because the dances and canoe races were held in different locations on South Vancouver Island every weekend during the season, families who had participant or spectator members would travel as a unit to the designated location. Conversely, the family influenced the community's spiritual orientation by organizing potlatches, healing ceremonies and vision quests for particular family members.

All members of the Band were invited to potlatches and ceremonies and special witnesses were called upon; whereas for healing ceremonies and vision quests, those Band members possessing the necessary qualities were requested to

participate. Whether it was total or partial Band involvement, the Native-oriented practices served to reinforce the spirituality of the community. The privilege of attending Native ceremonies, such as potlatch, pow-wow, workshop and canoe races and listening to family accounts of healings and vision quests clearly indicated the mutual spiritual effects of family and Band transactions. Family-arranged healing ceremonies and vision quests provided recognition to the Band and Band members of their special powers, spirituality and need to give leadership to other Band members; while family participation in Native oriented religious events strengthened their own Native identity and spirituality.

The Woman

Within the woman's Medicine Wheel, the elements of inner spirit "sinuit", sources of strength and relationship with the fetus were found to be important to her spiritual well-being. It was only after building up a sense of trust, over many interactions, that the Coast Salish and Songhees peoples talked about their own spirituality and personal "sinuit".

Sinuit" is not easily translated into English. The most usual term used is power.

> It is something like being full of the spirit - knowing the Indian ways, values and beliefs - living by them so you are an inspiration to others and they know that you have this - know just by learning from you.

This attribute is believed to contribute to one's health because it has the ability to make the person strong and to

prevent illness. Everyone is born with "sinuit"; the power is given to the individual at conception. The strength and quality of it, however, vary by individual and the mother's thoughts, actions and preparations can affect it. The inner-power is valued "as a gift". If the baby is to excel with its special gift s/he needs to have the gift recognized early in life by parents, grandparents or elders and fostered through good parenting. The individual has to be encouraged to increase her/his power and advance as a spiritual being. One of the more critical times in the Circle of Life to observe these requirements is puberty, preparing for adulthood. Strengthening the inner power is thought to be especially important to those who would be speakers, hunters, fishermen or clairvoyants, and in the past Shamen and midwives.

Although beginnings or essence of the power required for special roles was required, as only chosen individuals are born with special powers, if they do not use it, it dies. Thus, being born with this spirit is not sufficient to strengthen one throughout life. The power needs to be continually strengthened and renewed. If greater power is to be had, it must be sought after, possibly through quests, disciplines or initiation. For instance, the fires of the Longhouse help to renew the inner power and spirit and are believed to "help you live your life in a way that you are humble, but learn to live a life better than at the present." Quests are gifts in themselves because it is at this time, through disciplines and teachings, one has the privilege of learning about sacred Native ways and medicines and seeking one's own song and dance. It is a time for teacher and student to become part of each other. Disciplines and initiations, similarly, provide renewal and

augmentation of one's "sinuit". Both require purification practices such as fasting and bathing in cold natural waters. One of the goals in renewal or rebirth of the spirit is to develop one's senses "so you can almost feel how people are thinking".

Many of the women believed that they could tell the sex of their unborn child by how they felt and how they related to the fetus. In general, the woman pregnant with a male fetus was thought to have a more difficult childbearing period. Mothers of male babies stated that such pregnancies were different from those when they were carrying a girl. They carried the baby lower which make them feel larger and more awkward, experienced interruptions in their sleep habits, had to be put on salt-restricted diets and medications for edema and "spotted" during the early part of pregnancy. However, one elder reported that her grandmother had told her that male pregnancies were easier on the women. Thus, some discrepancy exists in the actual signs of the sex, but there it is generally assumed that differences in pregnancy experiences exist for each sex.

In a similar vein, a pregnant woman said she knew the baby was a girl because she "carried the baby high" and was very nauseated and sick. Whether or not there is consistency in the symptoms used to predict the sex of the baby is inconsequential. What is important is that most women felt that the special relationship they had with the fetus enabled them to "sense" the baby.

Believing in the ability to influence the fetus emotionally, socially and culturally, as well as physically, was reflected in the teachings, especially during the first

pregnancy. After this, the woman was supposed to know how to conduct herself during the childbearing period so she could have a positive influence on the baby's growth, development and spirit. Teachings, therefore included: how to live, what to eat, when to talk to the fetus, how to feel about one's self and being pregnant, and what kind of environment to live in during this period.

The Songhees mother's "sinuit" was found to be closely associated with her fetus and baby. Childbearing was a time of heightened powers. Therefore pregnant women were restricted in their social relationships so that this power would not have a negative influence on others who were believed to be vulnerable, such as initiates, dancers and fishermen.

When the women were asked about their source of strength and what contributed to their ability to cope sucessfully with the stresses and strains of Native life, mothers and then personal experiences were the two most important sources. Other sources were God, elders, children and other female relatives. Mothers were respected for their parental relationships with their daughters, for having endured many hardships in their marital and family lives and for their own inner strength and wisdom. Coping with difficult personal experiences was seen by the women as contributing significantly to their self-esteem and learning, which then became sources of strength. Not one woman had thought her life had been easy. Rather each spoke of the hard life all Native peoples had, especially having to choose between the Native way or the white way "because you can't just live like a Native".

Strength was defined as being stubborn, knowledgeable in Native ways and strong in body and mind. The woman valued this strength because it meant "knowing you can do it - you are as good as others" and because it was associated with respect and love from others. However, most of the women showed surprise, but delight, when they were acknowledged by the investigator, as being strong. Not one denied her strength, but many wondered what personal characteristics had indicated strength. All the women were pleased to receive the feedback.

A respected and loved elder summed up the notion of strength. "

> In life there are four directions - from each direction there is a strength. It is the personal and family involvement - really caring for one another's well-being - that has kept our people strong and unified. Spirituality comes from within, within your heart. It makes you happy. It's where your strength lies.

Another younger woman stated: "strength comes from beliefs, being together and prayer".

Summary

The Family's Medicine Wheel - An Environment For the Woman

According to the four directions of the Medicine Wheel, the family performs four major roles or functions as the environment for its members. The roles from north to west are provider, supporter, mediator and facilitator. The family environment is a microcosm of the Songhees community, just as the Band reflects much of the larger Coast Salish society and culture.

Within the physical directions of the Medicine Wheel the Native family is the **provider** of shelter and aid. Homes tend to have the basic essential services, space that is multifuncitonal and furnishings that are multipurpose. The family's home is able to accomodate more or fewer members depending upon the current need. Living rooms function as bedrooms, couches are used as beds and children double up with parents or other siblings. Except for the television, material goods do not seem to be important possessions. However, family photographs and Native artwork and crafts were proudly displayed.

The type of home occuppied by Songhees families is in part determined by the age of the parents. The younger families start a new life in mobile homes, or with parents, while the older families have larger, permanent family homes which may have been passed down through one or two generations. The most frequent reasons for the younger couples or families leaving their parents home were to have some private, personal space and to learn and practice the necessary skills for marriage and parenting.

Family membership, in this study, was found to include at least both parents and a child, except for the older women who are widowed. Frequently membership had included foster children. No single parent families were identified.Some marriages are "Indian" rather than legal, but the distinction was not important to the families.

Besides providing shelter and "belonging" the family provides instrumental and material support in terms of childrearing and financial aid. The extended family is expected to provide multifaceted childrearing inputs to

parents and children and to care for their relatives' children. There were no day care or nursery school facilities for young children; the children were looked after in someone's home. Families voiced concern that their parenting practices were perceived by non-Natives, especially nurses, as being inadequate, if not neglectful; yet they perceived these practices to be consistent with the Native way of life.

Native childrearing beliefs and values were taught and practiced to promote children's physical growth and emotional and cultural behaviour. If the parents had not been taught, or did not have the intuitive knowledge and skills regarding particular childrearing concern, they used family role models or advice for problem-solving. When that failed, the Native Band-employed Community Health Representative might be consulted. The last resource to be used was the doctor.

Instrumental and material aid was also given by families when they organized and sponsored ceremonies for family members, for instance memorials and potlatches for naming. Material aid in the forms of money, goods, physical health care and child care were given to family members of all ages.

Thus, the family provided a physical environment which contributed to the individual member's health and sense of well-being. The home, family membership, childrearing responsiblities and instrumental and material aid were identified through content analysis, as being important elements of the physical environment.

The family is also a **supporter**, offering varying degrees of support to the individual for carrying out health-related behavior and developing a sense of well-being for emotional health. Support was given through teachings about the maternal-fetal relationship and through love. Maternal and fetal emotional health depended upon the transactions between the two and between the mother and her environment. Love, looking after one's own, had the potential of building self-confidence and self-esteem.

The supportive role of families had both positive and negative outcomes, depending upon the impact it had on the individual's emotional health. Negative outcomes were associated with encouragement for the mother to engage in unhealthy behavior such as drinking. If the woman engaged in this behavior she often felt guilty; if she did not she was lonely and felt isolated. Other sources of negative outcomes for the woman occurred when family members were unaware of their needs or more fearful than themselves, and when their expectations of the family were not met by the members.

But, on the whole, the family was seen as positively supportive. Just having family members available was seen as supportive. Spontaneous support in times of crises and celebrations was related to this availability of family members. Feeling understood, sharing responsibilities and keeping the support within the family were also positive factors.

Mobilization of the family as supporter was found to be, for the major part, spontaneous. It occurred because of

members living together, visiting or considering themselves part of the family.

The socio-cultural direction of the family's Medicine Wheel can be compared to its role as **mediator.** The role required mediation between the individual and her community. The family was the culture-broker, transmitting beliefs and values important in giving direction to acceptable Native behavior. Respect was the most important value to be developed and practiced. Not only did this occur in one's family of origin, but when the woman married and went to live with her husband, his parents were important mediators or culture-brokers. Often the young couple lived with the parents during the first year of marriage.

As mediator, the family had the potential of developing positive family relationships, ethnic identity and self-concepts, as the most important social relationships to the Songhees peoples were the family relationships. The positive factors tended to be associated with family cohesiveness, a feeling of belonging and mutual support. Extended family relationships, which included young children and elders, were viewed as critical to a positive, healthy outcome for the family. They brought the family together. Disjunctive family relationships, such as those influenced by heavy alcohol consumption, were associated with a negative aspect of mediation. Role models and personal experiences in such situations reinforced the negative stereotypic behavior of the Indian - one that the Native peoples are attempting to overcome in the non-Native Society.

Family spirituality is a major **facilitating** factor in family health and the well-being of its members. Sharing values, practices and disciplines, as well as participating in Native ways such as healing ceremonies and vision quests as a family, facilitates the member's potential for developing her own spirit and power. Specific family teachings and traditions that make this possible are sacred to that family. They are not shared with other Native peoples and in some instances can only be practiced by certain family members. There is no doubt, however, that the spiritual environment of the family is a significant factor in determining the member's sense of well-being and health.

The family environment has been conceptualized within a Native perspective as a Medicine Wheel: A Medicine Wheel that is only whole when there is a balance among the four directions and a harmony with the community and Universal Medicine Wheel. The Native perspective is both holistic and ecological.

The Woman's Medicine Wheel: The Childbearing Experience

The childbearing experience, a normal but significant process in the Cycle of Life for Native women, exemplifies and magnifies the transactional processes that occur daily between women and their family environments. It provides an opportunity to examine the unique and common environmental and individual factors affecting both the fit between the woman and her family environment, as well as the harmony between the woman and her universe. Beliefs, values and practices specific to this time of life are extensions of those salient to the everyday ways of the Native peoples. In this respect, the members of the

Songhees Band are no different. Their uniqueness and individuality rest in the specifics of the teaching incorporating these beliefs, values and practices and their commitment or adherence to these teachings.

Commitment to the teachings was analyzed and conceptualized along a continuum from low to high commitment: from expressing awareness of the teaching of the belief, to seeing its value in other's behaviors, to practicing it oneself. Teachings about the childbearing experience included matters related to diet and nutrition, activity and rest, emotions and labor and birth. When these were analyzed, differences between childbearing and non-childbearing aged women were observed. (Figure 19) The vast majority of the teachings could be categorized as traditional. Few were identified as contemporary. Those that were not described as traditional teachings were frequently relegated to the status of intuition or common sense. Thus, degree of commitment is essentially related to traditional Native ways of life.

In general, the older, non-childbearing women reported a greater degree of commitment to the teachings, with less diversity in their level of commitment than the childbearing women. The majority implicitly and explicitly noted an association between the teaching and the outcome, spoke of the practices of others or described their own adherence to the teachings in all four areas: diet and nutrition, activity and rest, emotions and labor behavior. (Figure 19). None of them considered the possibility that the teachings, except for diet and nutrition, might be old wives' tales or superstitions. Commitment to teachings about emotions and their impact on the fetus and later

child development were particularly high - levels 3, 4 or 5. These teachings were very similar to the belief in one's inner spirit and power, or "sinuit". They were teachings that were integrated into one's daily life outside of the childbearing experience. The other teachings that were specific only to the childbearing experience were found to generate a low degree of commitment as well as a high one. Diet and nutrition, activity and rest and labor behavior are teachings that are directed to, and meaningful for, the woman experiencing pregnancy and birth. Thus, lower levels of commitment on the part of older, non-childbearing women might be expected because it is no longer necessary to practice them.

The childbearing women indicated a strong sense of commitment to the teachings they received during the specific childbearing periods. This was particularly emphasized with their first experiences, where close guidance was provided by relatives. The degree of commitment was reported higher by the childbearing women than by the non-childbearing women, i.e. for carrying out the practices themselves; whereas level 4, commitment, noting other's practices was less frequent for the non-childbearing women (Figure 19). Similar to the older women, none reported teachings about emotional health as superstitious or old wives' tales, and the frequency of this level of commitment with the other teachings was very low. The greatest ambivalence in commitment, levels 2, 3 and 4 was perceived by the Songhees childbearing women as causing greatest dilemmas for them. Although many childbearing aged women reported on the diet and nutrition, and activity and rest teachings, they found it difficult to be committed to them for a number of reasons. Some women reported conflict

with non-Native teachings; others described family situations that were non-supportive - e.g. with respect to consuming alcohol, participating in competitive sports or attending prenatal classes. The lowest level of commitment to the teachings was found in labor behavior. Indeed many of the childbearing women expressed disappointment in not being able to maintain the stoicism, an expectation of the Native way of responding to the discomforts of labor and birth. For many of the women, it was behavior they wanted to improve with their next experience, without the aid of medication.

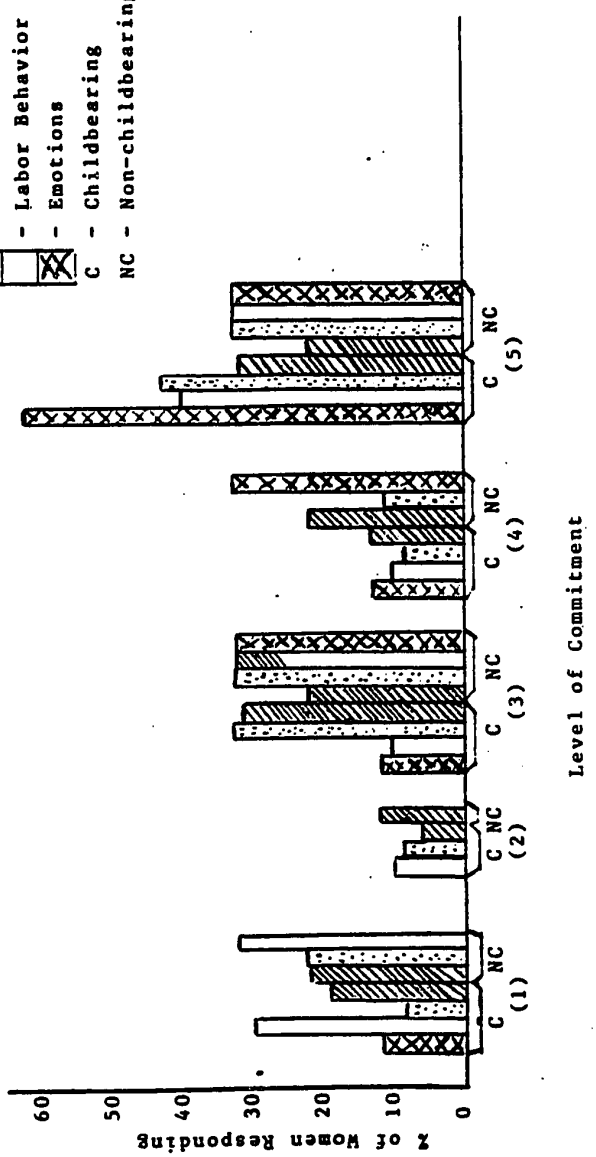
The major **sources of teachings** and knowledge were mothers, mothers-in-law and grandmothers. It really depended upon who was living in the closest proximity as to who would take the responsibility for teaching, particularly during the first pregnancy. Responsibility did not end at teaching, but included monitoring the mother's behavior and providing ongoing encouragement and support. Other female relatives, such as sisters and aunts, were considered important teachers; women reported relying upon their own intuition or common sense as important in directing their behaviours during the childbearing experience. It was impossible to determine whether the self knowledge was due to prior teachings about the Native way of life, inner powers or previous exposure to others' experiences.

Thus the primary source of knowledge was the popular health care sector. The folk sector, which might be considered as including the Community Health Representative, and the professional sector, nurses and doctors, were rarely identified as sources of knowledge. When they were, it was primarily for advice and support in labor and birth.

FIGURE 19

Summary: Level of Commitment of Women to Childbearing Teachings

Childbearing (n=6) and non-Childbearing (n=4) Women



The teachings were almost exclusively taught during the childbearing period, or at the time of the event, such as labor.Adherence or non-compliance to the teaching was thought to have its major effect on fetal and infant growth and well-being. The baby was the focal point, the sole reason for carrying out the teachings. Characteristics of the baby, from physical markings to social behaviour, found explanations or associations in the prenatal behaviour and attitude of the mother.

Additions or restrictions were the major requirements of teachings. In only a few instances was no change required. Because childbearing is a normal part of the Cirle of Life,unless something goes wrong, no change is required in one's usual role of responsibilities. One is expected to carry on daily life as usual. An announcement of pregnancy is not usually made, instead one hears by word of mouth and does not ask directly. The restrictions were found in diet and nutrition teachings, as well as some specific socio-cultural relationships whereas the teachings about activity and emotions included additions or changes in a positive direction. None of the teachings about the childbearing period were considered to be harmful to the mother or fetus, as long as the mother substituted appropriately for the dietary restrictions of protein foods. The additions that were advised were of a beneficial nature. The teaching of "no change required" might be considered to be questionable if it deters the woman from seeking early and continuous prenatal care.

The woman's lifestyle practices involving the use of cigarettes and alcohol were associated with both family behavior and cultural expectations. Where the traditional family

teachings about abstinence existed, the influence of family role models and individual choice predominated. Knowledge of contemporary teachings and advice was limited, but for a couple of childbearing women these influenced their decision to change their drinking and smoking behaviors. Failure to consistently abstain engendered feelings of guilt and anxiety in the women; while abstaining carried its own toll of isolation and loneliness as the women did not participate in everyday social events.

However, the **strength** of the women, and their strong feeling of a special relationship with the fetus contributed to a more positive self-concept, which in turn, as they described it, gave them the self-confidence to manage their lives. On the whole, both groups of women had positive self-concepts and a strong sense of Native identity. The sources of these intrinsic qualities were attributed to their mother's input, the family relationships and experiences of living as a Native woman in a predominately non-Native society.

The Woman - Environment Fit

In summary, the Circle of Life of the Native woman during the childbearing period is not only intricately enveloped in her personal Medicine Wheel, it is invariably enmeshed into and influenced by her family Medicine Wheel. Her self-concept and ethnic identity, essential in determining her level of commitment to the teachings, are mediated by her family environment as she transacts with the members of her family and Band. Harmony between the woman and her family and feeling a sense of cohesion, belongingness and support, facilitated her adherence to the teachings. A

positive relationship with her female relatives, where emotional and instrumental support was acknowledged by the women was viewed as influencing behavior as well as feeling of well-being. The family was important to the women in the promotion and maintenance of their physical, emotional, socio-cultural and spiritual health. Values that were treasured by the women, their families and band and were apparent by what the Native peoples said and did, were the following: recognition and appreciation of their cultural diversity, recognition of the interdependence of people and the environment, acceptance of a higher being, a Creator of all things in the universe, use of intuitive as well as analytical thinking, a sensitivity to and respect of others and sharing among family and band members. These long-standing values have endured the close contact and at times suppression with the non-Native society.

A Family Environment Typology has been constructed around family environment and transaction chararacteristics that were found to be important for childbearing and non-childbearing Native women in their level of commitment to traditional teachings (Figure 20). Six variables were found to differentiate between women who reported high and low commitment or adherence to the teachings. One was related to environmental characteristics, four were associated with types of transactions, and one was person-oriented. Characteristics of family environment, ethnic identity, self-esteem, language, teaching-learning and drinking orientations found to be associated with levels of commitment and consistent with findings from other Native studies that investigated healthy growth and development of children (Burke & Sawyer, 1984), social psychological adjustment to urban living (Miller, 1979),

and mental health (Brink, 1984; Shore, et al, 1973; Warheit et al, 1975). One of the most persistent personal and community characteristic associated with health concerns in this and other studies was the orientaion to alcohol use. This concesus was further substantiated when the investigator participated in the Native family alcohol treatment program and continued the Coast Salish research among other tribes on the Northwest Coast of British Columbia. The results of this endeavor added validity to the interpretation of the findings amongst the Songhees Coast Salish peoples.

The six variables were perceived and experienced differently by the older and younger Songhees women (the non-childbearing and childbearing), as well as within each age group. Within each age group it was possible to determine differences in each variable associated with high or low commitment to the teachings. High Commitment included self-practice of the teaching, describing others' practice of it and noting the relationship between the practice and outcome. Low commitment was defined as being able to recount the teaching only or suggesting dissonance or skepticism with the teaching.

The usefulness of this typology in predicting Native women's behavior remains to be tested with other Coast Salish bands and Canadian Indian tribes. Further research may identify variables that are salient to predicting commitment levels to teachings by women in urban vs. rural living situations, women participating vs. observing only in Native Ceremonies and rituals, and women experiencing high or low self-esteem and/or ethnic identity.

FIGURE 20

FAMILY ENVIRONMENT TYPOLOGY

Age of Women	Commitment to Traditional Teachings: High	Commitment to Traditional Teachings: Low
Childbearing	Family - cohesive, receive instrumental & material aid, sense of belonging, living with/near family of orientation/extended	Family - living with husband's reserve or family, little contact with family or orientation or extended
	Ethnicity - participates with family in cultural/spiritual events	Ethnicity - support non-Native marriage, discrimination no problem, many non-Native friends, interrupted reserve living
	Self esteem - self respect, as good as others, improving, strength from mothers	Self esteem - lack self-confidence, aggressive, good as others, strength from experience
	Language - wants to learn Native	Language - no preference for Native
	Teaching-Learning - wanting to learn, seeking, available, integrated & residential school, explicit & implicit methods used in family	Teaching-Learning - not ready to learn, missed opportunities, skeptical, mother poor role model
	Drinking - usually, no problem; pregnancy - none/little, some teaching	Drinking - usually, no problem; pregnancy-little change, no teaching
Non-Childbearing	Family - cohesive, proud, offer instrumental/material aid, visits extended family, arranges Native ceremonies	Family - changed Bands, few resources to give material aid, few older family members living
	Ethnicity - participates in Native customs, knowledgable of Native ways, continuous reserve living, sense of responsibility for Native	Ethnicity - attends Native activities, tried both reserve and non-reserve living
	Self esteem - pride in Indianness, family heritage, recognition of inner power, strength from mother and experience	Self esteem - doesn't see self as strong, lacks self-confidence, feels discrimination
	Language - knows Native	Language - knows some Native, some English, neither really well
	Teaching-Learning - teaching others, seeking opportunities, explicit, informal teaching	Teaching-learning - hesitant in teaching, skeptical, poor mother teaching relationship, perceives lack of knowledge, implicit informal methods when teaching/learning
	Drinking - occasional, self-no problem, past family (father) problem; pregnancy - none- teaching	Drinking - usually, sometimes self-problem, past family problem; pregnancy - little or no change, no teaching

CHAPTER VII

DISCUSSION: INTERPRETATIONS, IMPLICATIONS AND SUMMARY

Introduction

The general purpose of this study was to determine the tradional and contemporary childbearing beliefs, values and practices among a group of Coast Salish native peoples. Further to this was the intent to develop an appropriate conceptual framework from both emic and etic perspectives for further development of nursing theory and to propose hypotheses that might be tested in future studies. A descriptive, grounded theory method was used for this ethnographic study, with concurrent and subsequent data analysis being implemented by constant comparative content analysis. Data were obtained throughout the continuum of participant observations. Native ceremonies and reserve living provided rich opportunities for observation, while participation in Native Health Committee Meetings and Workshops and Native Health Clinic Society Board meetings was used to validate perceptions and establish trust. The majority of the data, however, were derived from in-depth interviews with ten woman and numerous discussions with Coast Salish informants, all members of a Coast Salish tribe living on South Vancouver Island. All the women belonged to the Songhees Band of the Coast Salish tribe. Except for one woman, whose application for reserve housing was pending, all lived on the reserve.

A conceptual framework was derived from two sources: general and specific. The general source was a review of research and theoretically-oriented literature. It included cultural and transcultural studies of childbearing and self-concept,

literature about cultural patterns found in health beliefs values and practices and selected theories of environment, ethnicity, self-concept and nursing. Theories of communication, learning and cognitive dissonance were reviewed to incorporate a process dimension i.e. transactions, to the conceptual framework. The specific sources were empirical evidence gained through experiences of working with Native peoples and literature written by Native peoples or about their ways, health status and behavior.

The Native perspective guiding the development of the conceptual framework was the value they considered critical to the integration of life from conception to death, i.e. living in harmony and balance with one's environment. This basic tenet provided the rationale for considering the family as the childbearing woman's immediate environment in which transactions occur and degrees of harmony, balance and well-being result. Concepts of holism and holisitic care, and person-environment fit and adaption were indentified as essential to the future development of nursing theory and health care policies. Based on two similar and complementary perspectives, the requirements for well-being for the mother and her off-spring were conceptualized as incorporating both content and process. The Native Medicine Wheel gave structure to determining the salient content elements, while theories of transactions provided process concepts. The four recurring content concepts were physical, emotional, socio-cultural and spiritual well-being for the childbearing woman, as well as for her family and community.Education, including teaching and learning, communication and ethnic identity as a Native and a member of the Songhees Band were process concepts

important to understanding the interactions that occurred between the woman and her family. Together the content and process concepts defined the integrity of the Native way of life within the Circle of Life.

Individual data were combined and included with observational and participatory data for analysis to formulate a composite presentation. Emic data were presented and organized according to the process concepts first, so that the dynamic quality to the conceptual framework and content elements could be appreciated. Integrated into presentation of the process qualitative data was the analyses of quantative data obtained from the administration of two scales (Ethnic Identity Scale and Self-Esteem Scale) to the ten Songhees women. The qualitative data analyses were presented as that derived from 1) all Coast Salish sources, except the ten women, 2) Songhees women past the childbearing age, and 3) Songees women presently in the childbearing age or period. The quantitative data analyses compared the women of childbearing age with those on non-childbearing age.

The content data were organized and presented according to the emic categories of the four directions of the Medicine Wheel. Within each direction, elements of both the family's and individual's Medicine Wheel were described. The origin of the elements were indentified as tradional or contemporary. Data from general informants, observations and participations were included in the general description of the element, whereas specific comparisons were made between childbearing aged and non-childbearing aged women regarding the specific teachings suggested a continuum of commitment, form low to high. It was possible to analyize

teachings about physical, emotional and socio-cultural well-being according to this continuum. Presentation of the analysis was made diagrammatically.

To retain the original Native perspective, the holistic nature of the Medicine Wheels was described for the community (Chapter IV), the family and childbearing women (Chapters V and VI). Both content and process concepts were integrated into the major categories of family as environment and woman as a childbearing individual. A Family Environment Typology was constructed based on family and personal variables associated with childbearing and non-childbearing Native women's level of commitment to traditional teachings.

INTERPRETATION

At the beginning of this study, three questions were posed by the investigator. The findings will be discussed in relationship to these three questions. Each research question will be discussed separately and the findings interpreted from emic and etic perspectives as suggested by the conceptual framework development.

Interpretation must be made carefully and with a cultural sensitivity. Generalizations cannot be made, neither to West Coast natives nor the Coast Salish. In fact, generalizing within the Songhees Band is not advocated because of the possible non-representativeness of the sample of women and the fact that selection of, and opportunities for, observation and participation were based on convenience or acceptance. Although the ethnographic grounded theory method, as implemented in this study, used

extensive consul-tation with Native peoples to establish validity of the breadth and depth of the findings, interpreting a non-Native's interpretation of a situation is at best a second or third hand view.

Question 1: What are the cultural meanings Native peoples use to organize the childbeariong experience and behaviors?

The childbearing experience was found to be very important to the Coast Salish woman, as well as to her family and community. The experience meant a change in status from woman to mother or from parent to grandparent.The role of mother is much valued among the Native peoples, not only because of the contribution of children to Native society, but for the fulfillment of individual, family and community expectations regarding the general role of women. Grandparents are respected for their experience and wisdom; grandchildren provide the opportunity for role fulfillment. Grandparents are expected to be the medium through which traditions, disciplines and teachings are learned.

The experience of childbearing is considered to be both normal and special. It took on a normal or regular meaning because it was anticipated to be part of every woman's life: an experience that was expected, if not encouraged, to complete the Circle of Life. Wholeness of the Circle of Life is based on experiencing critical stages, such as puberty and childlbearing. Unless something untoward happens during the childbearing experience, it is considered to be normal, but requiring adherence to a number of teachings and discipliness, because it is a special or vulnerable time for the pregnant woman. The definition of "pregnancy as normal" is consistent with

Horn's (1975) and Bushnell's (1981) findings. Unless something untoward takes place, the changes that occur during pregnancy are considered normal or regular and require no consultation outside the native system. The teachings and disciplines of the native way of life are generally considered sufficient to ensure a healthy outcome.

Like other critical periods in the Circle of Life, childbearing is considered a time when the woman's inner spiirit, "sinuit" can be especially powerful and influence others who are particularly vulnerable at the time. At the same time it is a period of vulnerability because of the integral relationship between the mother and conceptus, whose development, it is believed, can be seriously affected by the mother's physical, emotional, socio-cultural and spiritual experiences. The ability to have children makes a woman very powerful in the Native culture. For the family, childbearing is believed to be an important source of blessing because children carry on the person's memory after death. Parents and grandparents are responsible for identifying the child's potential spirit early in life, fostering it and naming the child for a relative who had possessed specific characteristics.

A third meaning the childbearing experience has is at a community level. It is valued as a means of contributing to Native society and "Indianness". Not only does it increase the Native population, but it affords an opportunity of teaching the Native ways of life and encouraging a strong ethnic identity. In the past it has been a honor that women should bear and rear the children,

ensuring that there would be a people of the future (Hungry Wolf, 1982).

The significance of each of these meanings: status change for woman and family, contribution to the fulfillment of Circle of Life and enhancing Native society and culture - is reflected in the reported and observed beliefs, values and teachings. Although confirmation of pregancy is often made with the physician, further prenatal care in the non-Native health care system is limited. Attendance at prenatal classes was an exception, with two of the women havaing been to two or three of an eight-class series. Visits to the physician are irregular, and in part depend upon whether or not anything irregular occurs during pregnancy. The irregularity has to be considered significant enough to seek outside help though. Symptoms of labor usually result in physician consultation, a pattern which has not changed significantly from that reported by Graham-Cumming (1967) or Horn (1975).

The experience of childbearing is considered to be essentially a socio-cultural process. A spiritual meaning is interwoven throughout this process, signifying it as "special", " blessed" and " sacred" time. The power of one's own spirit, "sinuit", as well as that of others, directs much of the behavior of the pregnant woman in both her social relationships and personal lifestyle practices. Disciplines and practices of the Shaker Church or Longhouse touch almost every woman's life during childbearing, as well as other times in her life. They are reinforced by teachings of family members or elders throughout the childbearing period.

Native peoples also view children as the wealth of their nation - "They are our future". The meaning attached to children is evident in the rationale or explanations given with the traditional teachings. With few exceptions, the expected recipient of adherence to the teachings is the offspring; occasionally the mother is the intended benefitor with an easier labor being purported. The Coast Salish cultural meanings given to childbearing are similar to ways reacting to pregnancy identified by Mead and Newton (2967) in their classic study of 222 cultures found in the Human Relations Area Files.

When women were asked about childbearing or pregnancy, they initially focussed on labor and birth. Even though their personal experiences might have been more than 15 or 20 years ago, they have vivid recall of them, especially their first. For women in the childbearing age, unsolicited detailed accounts were given from the onset of labor through birth and occasionally post partum. It was only through more specific questioning that events during the prenatal period were discussed. When the investigator focussed the interview in this direction, the women made a conscious effert to recall their experiences or teachings from their mothers and grandmothers. There was not as spontaneous a response as that with labor and birth. This finding adds support to that of Horn's (1975) and Bushnell's (1981) that unless something abnormal happens during the prenatal period, it is considered normal and not to be treated as illness requiring medical consultation or assumption of the sick role.

The woman's first childbearing experience is seen as the most significant. It provides the initial opportunity for

learning the Native teachings and mothers and mothers-in-la are reported as being extremely thorough and watchful teachers. Although some learning occurs during one's lifetime, it is primarily through the availability of role models - mothers, sisters and cousins - and is considered general and implicit preparation for the new role of motherhood. Because the Coast Salish culture is patrilocal, the woman generally lives on her husband's reserve, and sometimes initially with his family. Thus, teaching during the first pregnancy is frequently the responsibility of the mother-in-law, with mother and grandmother contributions made through role modelling throughout family life or teachings during visiting. Opportunities within the past generation for learning beliefs, values and practices in the natural family setting are limited. Whereas there is a traditional closeness between elders and grandchildren so that the children are exposed to the same values as their parents were raised by, contemporary experiences with residential schools and mobility among reservations has disrupted this relationship and transmission of cultural heritage. Today, if traditional customs are to be observed, a determined effort has to be made by the women or members of her family. Many of the childbearing women remarked on their need to learn more about the Native ways to be good parents with the ability to teach their children. Childbearing provides the opportunity for working through feelings about being parents, as well as being Indian. It is an opportunity for them to reflect on how they learned, what they learned and the importance of the teachings.

Thus, the childbearing period not only engenders ethnic identity through the cultural meanings attributed to it;

but it instills a future orientation to learning and teaching Native ways. The cultural meanings focus on Native beliefs and values and form the basis for continued emphasis on Native identity.

With such a strong orientation towards a Native perspective, it is not surprising that the non-Native health care hystem is used sporadically, without a great deal of faith. What is to be recognized in this analysis is the opportunity to teach Native health-related beliefs and practices important throughout the Circle of Life, as well as during childbearing. In the past grandparents have been particularly respected for their teachings. Their role, as well as that of elders, is acknowledged among the Coast Salish peoples as essential to their own education. Analysis of the data indicates that the teachings contained three elements: beliefs and values, knowledge and behaviors or practices. These are similar to Horn's (1975) analysis of emic statements, where the three elements were perceptions, cognitions and actions. Any attempt to provide meaningful health care to childbearing women must recognize the cultural meanings of the process, the role of Native teachers and the need to include beliefs, information and skills in learning situations so that the individuals can develop their own Native system contiguous with that of the Coast Salish culture, become more knowledgeable about the childbearing period and practice the behavior that is expected. This in turn influences the development of a positive self-concept.

The childbearing experience is perceived as a normal part of healthy living and health or well-being is viewed as a resource for everyday living. This is similar to the

W.H.O. conception of health "as the extent to which an individual or group is able, on the one hand to realize aspirations and satisfy needs; and, on the other hand, to change or cope with the environment "(WHO, 1984: 2). The similar perceptions suggest that health is a positive concept that emphasizes social and personal experiences, as well as physical capacities. Thus for the Native Woman, childbearing is a social and personal experience in which one builds on physical capabilities and changes, modifies or copes with the family and community environments.

Question 2: How do they (the Coast Salish peoples) interpret the outcomes of these behaviors and experiences?

Unlike the Western perspective, the Coast Salish have traditionally taken the view that the really significant part of the life of the individual begins from the time of conception. During the study many beliefs and practices were told to the investigator or discussed among family members when the investigator was present. Beliefs about pregnancy in general and teachings specific to the prevention or promotion of fetal, and sometimes maternal, outcomes were shared by the women and informants. The general beliefs are similar to those held by the Bushnell's sample of six Native American women living on a coastal reserve in Washington (Bushnell, 1981). Discussion of the general beliefs, and especially the more specific practices surrounding fetal well-being, were only occasionally alluded to as old wives's tales or superstitions. The younger women were more hesitant in professing belief in some of the teachings until they trusted the investigator to maintain her respect regardless of beliefs held, the explanations given or the teachings practiced. Montagu

(1962) cautions that old wives's tales may be a great deal nearer the truth than are many learned professional teachings and that folk beliefs are sometimes based on a foundation of fact. Environmental effects of maternal nutrition and activity have been well documented within the biomedical model; whereas the maternal emotional state influence has been viewed by many health professionals with some skepticism. There does appear, however, to be some possible physiological mechanizm operating that can explain the influence through the maternal automatic nervous system in interaction with the endocrine glandular system as the neurohumoral system within the fluid matrix of the blood and its oxygen and carbon dioxide components is capable of transmission across the placenta (Montagu, 1962). Clearly there may be more validity to the Native teachings than is readily apparent.

The explanations as to why certain outcomes occur differ among the scientific community and the lay peoples, and within each of those two sectors. Not only do some of the explanations differ among the Coast Salish peoples, the women identify different levels of commitment they have to the teachings, from a high, i.e. practice of the teachings about emotions and spirituality. The lowest commitment was to teachings about activity and rest, yet these were where improvements are stated as personal goals of many of the Songhees women.

When asked what they would like to do differently in a subsequent pregnancy, all the childbearing women wanted to be more physically fit at conception and maintain that level and activity throughout the childbearing period. Similar to Whites (1970) findings, Indian values may

reflect the ideal but the behavior may suggest different intracultural dimensions depending upon the situation. One cannot infer the value from the role or the role from the value, because the intrinsic value of any behavior is situational. For some of the childbearing women, low commitment to the teaching may be the result of a tendency to retain their "Indianness" while struggling with the almost daily contact with the dominant culture. Learning about their Native values may result in knowledge and beliefs, but not behavior (Trimble, 1976). Access to appropriate environmental amenities in which to carry out physical fitness, except for walking, are also considerations to take into account when analyzing actual practices.

Another explanation for discrepancies in the level of commitment to the teaching may be related to the woman's age. Analysis indicates that non-childbearing women, in general, have lower commitment than the younger childbearing women. Because they were no longer able to bear children, they described their past experiences, as well as what they were teaching their daughters. Therefore, they may speak mainly in terms of what ought to be done and why, not what was done.

There may be a third reason for lower levels of commitment for some of the teachings. In general the teachings dealt with what to do or what not to do and related to an expected outcome - usually the offspring. They were not helpful in preparing the women to handle the process and the women said that they had not been prepared for the physical and emotional changes in pregnancy nor for the labor experience. The women indicated they wanted to know what was going to happen to them at various stages, but did

not know how to ask the questions of their families or health care professionals. They were seeking a knowledge level that the traditional teachings did not address, and therefore commitment may be low because a different type of information was needed by the women.

The offspring was the identified benefitor of the woman's high level commitment to the teaching, according to the native perspective. This is consistent with the cultural meanings attributed to the childbearing experience. The teaching related either to additions or restrictions in the four directions of the Medicine Wheel.

From a biomedical perspective the teachings were analyzed according to the four categories used by Williams and Jeliffe (1972) in their investigations of indigenous practices. Teachings were considered **beneficial** if they were valuable to health. **Harmless** teachings had no obvious health or disease effect on the mother or unborn, whereas **harmful** practices were those that had deleterious effects on the health of mother or unborn. Teachings that were neither harmful nor beneficial were considered **uncertain.** None of the teachings were considered to be harmful. The potential danger of dietary restriction of protein is reduced because of the variety of foods available and eaten in substitution. Therefore no teachings require modification because of harmfulness. Many of the teachings about diet, activity and emotional well-being may be of benefit and could be actively encouraged and adopted.

Restricting fatty, heavy foods, encouraging fluid intake of water and juices and discouraging alcohol and cigarette use

are healthy teachings, as are those advocating activity but restricting heavy lifting. Teachings about the emotional well-being and its influence on a fetus may be of more benefit than is presently understood and could well be incorporated or modified into Westernized practice.

There were some teachings based on the spiritual aspect of the childbearing period that were difficult to assess. At best they were harmless and required neither modification nor encouragement. However, they could also be within the uncertain category requiring further observation and consideration. The power of one's spirit and the subsequent need to restrict social and cultural relationships, the care of the placenta and umbilical cord, and the use of massage to shape the baby's features are examples of the uncertain category.

Although, in and of themselves, none of the beliefs and practices were considered to be harmful, the Coast Salish value system does affect the women's health seeking behavior. Similiar to Horn's (1975) sample, the Coast Salish women tend to seek care when they think there is something irregular or abnormal about the pregnancy. The traditional teachings center around actions to be taken to maintain a normal, regular pregnancy and the expectation is that the childbearing process will be normal. This perspective could be interpreted as having the potential of inhibiting or delaying the women's entry into the professional health care sector. The health seeking process is determined, in part, by how the individual defines her symptoms or feelings of illness and the explanation she gives to the cause. If she either does not define pregnancy as irregular or a state of health

requiring professional care, or she assumes the cause of irregularity to be spirit or culture-caused, she is unlikely to seek care outside the Native context. There is little sense in going to a Western health care professional who does not have the skills or knowledge to deal with the perceived cause and who may be critical of the Native explanation or practices. The same may apply to prenatal classes and child health conferences. Very few contemporary teachings were identified. Those that were related to smoking, drinking and dietary salt restriction, and were considered by the women as something they "just know wasn't good" or "had heard someplace". The professional health care sector is not used as a source of childbearing teachings, mainly because it was not specifically organized to include non-white, middle class needs. An out-reach orientation was indentified as being required, as will as a Native sensitivity. Frequent use of the popular and folk sectors by other Coast Salish peoples regarding other health issues suggests considerable validity to this argument. Healing ceremonies, Shakes, Indian Medicine and self-care are described and observed throughout the reserve for a variety of health concerns: diabetes, blindness, arthritis and Alzheimer's disease. In the past these practices were also an integral aspect of the childbearing period.

In conclusion, the Coast Salish peoples interpreted the outcomes of the childbearing experience in terms of the mother's adherence to the teachings and the family's ability to transmit the necessary beliefs, values and practices.

Behaviour that violates the teachings, for example eating crab or drinking alcohol, but does not result in the expected outcome leads to skepticism and questioning regarding future adherence. Several women who had drank during pregnancy, or knew others who had, but did not have recognized FAS children, questioned the belief that alcohol causes detrimental fetal effects. Instead they continue to believe that one has to be an alcoholic before untowardeffects occur. Alcoholism is synonymous with a drinking problem that can not be controlled. Some people who admit to having a drinking problem do not consider themselves alcoholic, because they feel that they can control their drinking behaviour. On the whole, outcome evidence of detrimental behaviour is the single strongest reinforcer to commitment to any of the teaching.

Question 3: What are the perceived family environmental factors that influence the ability to have a healthy pregnancy and baby?

The family is considered to be the most important and immediate environment for the woman. It includes both family of orientation and family of procreation. Physical, social, emotional, cultural and spiritual factors, as well as the transactions that occur among the members and the women, are described as being important to the well-being of mother and baby. The relationship between the family and reserve is perceived as a transaction that influences the childbearing woman as the family expresses the Songhees Band cultural environment. The family's ability to interpret value and belief systems and behavioural expectations as socially acceptable rules and norms is

considered to be an essential process (Logan and Hunt, 1978).

The family environment is described as being both supportive and non-supportive, having very positive influences, as well as some negative ones. However, the major impact on the woman, as viewed by them, is positive and supportive.

Factors in the physical environment that are supportive are living on the reserve and receiving both instrumental and material aid. Reserve living has both economic and socio-cultural advantages. Members receive medical and dental aid, income tax benefits and housing assistance while living in a community that is culturally homogenous and socially close through family relationships. Even though there are some problems described with living on any reserve, such as favored status with the Band Chief and Council decisions, inadequate housing or excessive drinking, it is the preferred living location for all women and informants.

Instrumental and material aid is received from the family as needed. It was most frequently offered as money for household expenses or travel, gifts and child care. Because of age differences, the older women usually describe aid given, while the younger women acknowledge that received. Both groups, however, emphasize the value of sharing in both directions and the expectation that members will contribute when they were able to do so. Material aid is often withheld for purposes of buying cigarettes and alcohol, even though parents themselves engage in the behavior.

Availability of family members and spontaneity of relationships are important factors of the family's emotional environment. A supportive, positive environment is described as one in which there is encouragement to do the right thing, an understanding of what the woman is experiencing, an interest in the baby from the time of confirmation of the pregnancy and an ability to teach at the time of the event - or when the need arises. Horn (1975) found that these were expectations of both family of orientation and procreation as helpers. The most frequent references to a non-supportive emotional milieu were family or spouse encouragement to go out drinking and indifference shown to the pregnancy.

The supportive, positive socio-cultural factors of the family environment include caring, cohesiveness and role-modelling. Not being part of the family or not having a sense of belonging were issues that created anxiety for the woman moving to her husband's reserve and sometimes into his family home. Lack of knowledge of family relationships and traditions and Band beliefs and values is viewed as initially upsetting. However, in most cases the families became supportive over time as learning and acceptance occurred. Almost all the women told about the strength and support of their mothers as being vital to the development of their own inner strength. The mother serves as a role model as she demonstrates her strength and tenacity in dealing with everyday hardships of Native life and abusive relationships that often accompanied family drinking. Her teachings regarding these hardships and equality among peoples reinforce the positive effect of her role modelling. However, if the mother has experienced a negative

relationship with her mother or mother-in-law, she is often hesitant to teach her daughter. Reasons for this include lack of sufficient knowledge herself, concern about making decisions for her daughter and interferring in her life, questions of validity of the teachings and desire to spare her daughter the rigors of the practices. Analyses indicates that the transmission of the traditional teachings was interrupted across the recent past generations without being replaced by contemporary processes from family or others. Failure on the part of the mother or grandmother to prepare the woman for the actual changes in pregnancy or labor experiences is identified as a gap in the family's socio-cultural environment.

Spiritual factors also relate to the family environment. Elders, grandparents and relatives are perceived as supportive because of their general teachings of Native heritage and family traditions. They are described as the links with the community and its controls on social behaviour. Their wisdom, experience and time for others are characteristics which encourage a sense of well-being and health.

Cultural activities such as winter ceremonials and canoe races are seasonal occurrances requiring certain disciplines into which the elders have much input. There has traditionally been an expectation that all reserve members are not only responsible for their own social behaviour, but for alerting others to their behaviour when it is not acceptable. This was intended to be supportive

of well-being of individuals and of the health of the community. However, the elders' roles as decision-makers in the community is viewed by some as having a negative influence. Carrying out the role of decision-maker put them in a parent-child relationship with other members of the Band: members who wish to make their own decisions as responsible adults. One of the ways to deal with the parent-child relationship is to ignore or discount the teachings and in fact rebel.

Rebellion is expressed as moving away from the family environment and Native way of life and drinking to excess. It is seen as a means of decreasing or masking a sensitivity of the spirit or inner self and the forces of nature. Regardless of the reason, the outcome is a change in the holistic characterisitics of the family environment. Because alcohol is the most frequently mentioned family and band concern, attention is given to it here.

In the past grandmother generation, alcohol was not a part of the Native way of life, especially for women. Although men sometimes used it, occasions were infrequent, as was the supply. Therefore, the use of alcohol was not included in their teachings and role models were other extended family members with similar lifestyles. In the present mother generation alcohol became more important to the way of life of the family and couple. There was less contact with extended family especially across generations because many of the elders had died and the younger members were attending residential school. No specific teachings about the use of alcohol had been transmitted through the generations, but role models for drinking were becoming

more frequent, as was the access to liquor. The cultural expectation, however, was that alcohol should form no part of ceremonial life. The Shaker Church, Longhouse and CanoePulling required abstinence. Using alcohol meant turning away from these Coast Salish practices. The generation of today, entering the childbearing period are exposed to a variety of role models, but to very few, if any, Native teachings regarding the use of alcohol, especially during pregnancy. Although the social pressure to drink or not to drink does not appear to change with the childbearing period, a cultural requirement might. Because the woman is restricted in her social relationships of attending ceremonies, engaging in sports and being in contact with vulnerable Band members, an outlet for her social activities may be drinking with family and friends. The younger women may encounter non-Native teachings, but their contact with the sources of these is limited. In general, the childbearing women experience inconsistency in the teachings and expectations of traditional Native, contemporary Native and contemporary non-Native peoples. It should not be surprising then to hear that the real problem identified by Native peoples is not alcohol, but the family. The family environment described as a problem has the opposite characteristics of the family environment previously described as positive, the most significant negative one being a lack of family cohesion.

Invariably the family is viewed as critical to the well-being of mother and children. The ability to transmit the Coast Salish culture across and between generations is the basis for establishing a supportive physical, emotional, socio-cultural and spiritual environment. It helps to fulfill needs of security, identity and a

historical continuity. It has the potential to influence health of its members in both positive and negative directions. These considerations go beyond the usual definitions of social support (Cobb, 1976; House, 1981; Macelveen-Hoen and Eyres, nd) and include the concepts of mediator and family networks (Levin & Idler, 1981; Speck & Attneave, 1973).

Implications

Implications from an exploratory, ethnographic study are infinite. Indeed, that is the purpose of research, to not only answer questions, but to raise them. What is indeed difficult to do is to categorize the implications and questions in a meaningful way. For the purposes of thisstudy, the implications are discussed in five areas that relate to specific fields of knowledge and theory in the conceptual framework and literature review:

1. Traditional - contemporary childbearing beliefs, values and practices as related to communication, teaching and learning;

2. Dilemmas for Native women consistent with theories of ethnicity, self-concept and cognitive dissonance;

3. Culturally-sensitive health care related to health seeking processes, health promotion and illness prevention and health care policy;

4. Development of nursing theory using multiple methods and foci and developing conceptual frameworks that form the bases for hypotheses generation.

5. Research among the Native people, gaining entry and making it socially and culturally revelant

Traditional - Contemporary

Today's Native women, living on the Songhees reserve, are continuously confronted with two worlds. They make daily decisions regarding their behaviour in light of the beliefs, values and teachings of Native and non-Native peoples, as well as the traditional and contemporary ones among their own peoples. There no longer seems to be one best way of believing or behaving. The fact that few contemporary, non-Native beliefs and knowledge were referred to as influencing behaviour, raises the question - "why not"? Based on knowledge of the Native women's health-seeking behaviour during childbearing, it could be speculated that lack of contact, trust and culturally-relevant messages and media are the problems. The implications of these responses might stimulate the following questions.

1. Where should health care services be situated to make them available and accessible to all women?

2. How should the health care services be given to meet the knowledge and behavioural needs of childbearing women, and support the harmless or beneficial teachings of the Native way of life?

3. Who should provide these services either as individuals or team members?

4. What preparation of the health care professional is required to develop a sense of trust with the Native woman and her family?

5. When should teaching take place so that it is viewed as relevant and practical?

6. How useful is the Family Environment Typology to predicting the level of commitment to teachings, both traditional and contemporary?

7. Within the typology, what nursing interventions are appropriate to the family environment and childbearing woman.

Because many of the reported behaviours were based on intuition or traditional teachings, building on what is known or believed is a critical first step. This means that health care workers, and particularly nurses, require an indepth understanding of the culture and an ability to explore the beliefs and practices of the women. Including non-Native contemporary teachings in health care must bedone in the context of the Native value system, traditional teachings and situation. Conflict between Native and non-Native teachings requires special attention, possibly through consultation with the elders, to decrease the potential dissonance encountered in practice.

In the past, residential school education discouraged Native cultural ways. Much of the past tradition which was lost is now being rekindled and sought. The efforts have become means of sustaining a Native identity. The past and present Native teachings rely almost exclusively on an oral

tradition of communication, and to some extent observation of role models. The informal mode of teaching is seen as appropriate to developing the Native way of life. Specific, more formal teaching takes place at the time of the event, when it is time to learn. For the Native childbearing women today, occasions to learn about the general Native way of life are being sought. There is a paucity of written material by, or about, Coast Salish peoples to help with this. As a result,in order to learn the women must foster relationships with other Natives. Their emphasis is on learning the Native way and their mode of learning is through verbal communication and role models on an individual basis.

Efforts to teach contemporary, non-Native knowledge and behaviours will have to consider the priorities of the women, their style of learning and how their behaviours will be interpreted by their family and friends. Social learning theorists assume that whether or not people choose to perform what they have learned is strongly influenced by the consequences of such actions; that is behaviour is learned before it is permformed (Bandura, 1969; Kunkel, 1970). Cognitive field theory expands this notion to include the premise that a simultaneous mutual interaction occurs between the individual and her environment (Bevis, 1978). The transactions between the person and her total environment are important. Thus, knowing communication styles and environments of families will be essential to planning and teaching. For instance, the relevance of formal, teacher-led prenatal classes for Native parents is questionable. All factors imply that informal, one-to-one and older-to-younger learning experiences are most acceptable and expected. Books, curriculums and objectives

bear little resemblance to these other meaningful experiences.

That is not to say that the women are not interested in learning. Quite the opposite. They want to be better prepared in knowledge and behaviour for the changes that are going to occur. However, they do have some difficulty in phrasing questions, particularly those involving sensitive or personal issues. They feel "different" from those from whom they are seeking help. Blunt (1972) found that the most powerful single predictor of participation in Native adult education programs was alienation. Those least alienated from Native way of life, with greater trust in others (Native and non-Native) were most likely to participate. This suggests that plans for a comprehensive perinatal program should address the learning needs and styles of the Native parents, build on the belief and value systems and involve community members as planners and teachers.

Particular attention to the elders is necessary, as there has been a hiatus in the relationships and transfer of traditions across generations. Grandmothers of childbearing women have had the opportunity of learning from their parents, whereas their daughters were denied this privilege.The mothers of the childbearing women did not grow up with the traditional teachings and language, nor did they receive non-Native teachings about childbearing in the residential schools. Today's childbearing women have knowledge of a few traditional teachings, a few contemporary ones and no particular depth of, or commitment to, either. They are unsure of the relevancy of the traditional teachings, but distrustful of

contemporary teachings. They do not wish to be perceived as criticizing the Native way of life, yet do not want to alienate themselves from the non-Native health care system. Even though there may be a breakdown of the informal network for communicating expectations of childbirth, a changed form of communication exists. The women may not pass on "old wives" tales to the extent done in the past, but certainly cultural orientations and expectations of behaviour are communicated across generations. The professional health care worker must consider theories of cultural communication when incorporating "professional" teachings in perinatal care (Prosser, 1978).

Prenatal classes per se may not be an appropriate medium for perinatal care for Native peoples with a tradition of oral transmission of knowledge, values and beliefs, whose family is responsible for teaching and where individual responsibility and autonomy are valued. Acting upon information regarding risks may be delayed or withheld for a variety of reasons: because the information is not consistent with traditional beliefs and behaviours, is not given through the appropriate channels, is not integrated into the general lifestyle, or the cultural strengths are not used as supports.

Prenatal classes, and educational programs in general, are perceived by Native peoples as being "difficult": not because the women do not want to learn or the elders do not want to teach, but because traditonally teaching takes place when the time is right - when both the teacher and learner are ready. Teaching cannot be suddenly turned on.

Implications of such findings could lead to developing a mode of message transmission possibly through those responsible for leadership in ceremonies, individual connections with families and Native studies in schools. The message might be put to songs or dances, poetry or visual displays. As purveyors of health, professionals must learn from the Native peoples' experience that to lead a healthy life you have to maintain a connection to a special thing other than yourself. An outreach approach should be considered, using appropriate Native women. Unique communication channels that exist on reserves, eg. dinners, tribal fairs, are opportunities for conveying certain messages. Tribal and urban Native organizations should be involved in adapting the media messages for specific Native populations. These organizations can be used, not only to provide relevant technical assistance, but to suggest appropriate means and models of communication.

Dilemmas for Native Women

The major dilemmas experienced by the Native women can be summed up as the challenge of learning to be Indian and feeling good about it. Ethnic identity and self-esteem are core concepts related to dilemmas, cognitive dissonance and changing behaviour. The dilemmas posed by the women could be viewed as arising from three major sources: Native - non-Native relationships, Native - Native relationships and self-family relationships. The dilemmas arose because of differences in value systems and social norms; differing values, determinants of social attitudes, ideologies and behaviour were experienced as inconsistent for the women as

they dealt with their own personal experiences and values in two diverse worlds - Native and non-Native.

Questions that arise out of such findings include:

1. When do Native women find themselves in these dilemmas and under what circumstances?

2. Who do they use for consultation in resolving the dilemma?

3. How are decisions made prior to taking a particular course of action?

4. What Native values are intransient, providing the innermost core of the Native woman's belief system?

5. What beliefs, values and attitudes can be conceived of as functionally organized around this innermost core?

6. How can the health care professionals work with others to reduce the cognitive dissonance and promote a healthy family environment?

Every woman attempts, at the very least, to maintain and in so far as possible, to enhance whatever self-conception she has managed to develop as a result of education within the Coast Salish culture and Songhees society, her family and personal experiences. Rokeach (1973) suggested that an induced change in self-conceptions (e.g. as a result of various experiences or education) should lead to changes in values, related attitudes and behaviours. Many of the women indicated a desire to improve their self-image

through gaining more self-confidence and attaining a greater sense of ethnic identity. Unless this is recognized by people in helping situations, increased pressure could be exerted on Native families to adopt values inconsistent with their cultural intent and increase the dilemma and dissonance for the women. However, education or re-education which enhances the self-concept and promotes self-actualization may facilitate awareness of contradiction and conflicts and lead to resolution of the dissonance.

At the same time emotional factors that support or hinder change and resolution require analysis and attention. The real impetus for change comes ultimately from the woman and family as change is a process of inspecting and comparing one's own values with others and deciding upon a course of action. The role of the professional health care worker may be to know enough about the beliefs, values and practices of the Native peoples so that she can elicit them and assist the woman in assessing them. Through assessment, dissonance and priorities would be identified and solutions considered.

The Native-non-Native dilemmas arose within work situations.The Native values that were used to organize one's work and solve problems were either not understood or not respected or tolerated by the non-Native employers. Attendance at cultural events, particpation in religious ceremonies, hesitancy to contribute to social interactions at work, and cautiousness in putting thoughts into words before due consideration was given were viewed by non-Natives as negative factors in the work environment relationships and resulted in employer-employee conflict.

Discrimination was a problem within the work setting and beyond. Co-workers at times avoided Native employees (making socialization even more difficult); Native ideas were not given equal status to non-Native suggestions for dealing with Native health issues; dress and habits required during certain seasons were criticized; and service in stores and restaurants was sometimes disrespectful.

Another source of Native- non-Native dissonance revolved around the residental school experience and other negatively-viewed Native-white relationships. The Native peoples at times discriminated against the non-Natives refusing them entry to reserves and Native life and declining even genuine offers of assistance. Residential school experience, while depriving the students of their cultural way of life, failed to prepare them for non-Native society. As one woman said:

> not that they were bad to us - but it was very lonely - and when I got out of there I didn't have any friends - they were all from somewhere else - I didn't know the ways of my family and I didn't know how to live off the reserve.

It is indeed believed to be difficult to live in two worlds. The frequency and magnitude of change in each that is required demands a maturity on the part of the woman in order that she can follow through on the teachings. The Native environment is not perceived by them as having the necessary resources to be able to deal with the changes required or to offer sufficient support to the families to revitalize Native beliefs and practices. The "critical mass" of Natives with strong ethnic identity is only now

being harnessed to overcome what has been lost to date through legal and school prohibition and early epidemics of small pox and tuberculosis. The will is there, but the means are still being sought.

There were some dilemmas identifed by the women as being within the Native community or between themselves and their Native identity. These included becoming pregnant outside of marriage, marrying a non-Native and providing birth control to teen-age daughters. Although it was evident that these situations were not desirable, the women expressed conflict in their own decisions regarding adherence to the Native values. The older women did not see the dissonance as an important factor, but rather that the young people just did not want to follow the Native ways because they were too much into the non-Native society of movies and television. The younger Natives felt caught between issues of assimilation and integration and encouraging the Native way of life.

Of considerable concern within the Native communities is the discrimination against Native women. The women seem to be of one accord in wanting equal status regardless of marrying a non-Native. However, the men are divided in their perceptions of the situation. Some agree with the women while others do not think the law had to be changed because the women had the choice and knew what the options were at the time of marriage. The women supposedly lose their Native ways when marrying non-Natives and are no longer considered Native peoples, according to these men. The children of such relationships are considered to be in a similar culture-deprived predicament. They apparently do not really know who they are, and when trying to become

Native, bring in too many non-Native values, such as competition, which tends to destroy part of the Native way of life.

The findings of this study suggest, however, that the Songhees women have a high level of ethnic identity and self-esteem, but are looking to increasing both by solving some of their dilemmas. The solutions include increased withdrawal from non-Native society, development of a Native determined health and social service system and increased family involvement in Native customs and ceremonies. If health care professionals are to be instrumental in improving the well-being of Native families and childbearing women, they are going to have to do it within the context of increasing their knowledge and respect of Native ways, "learning from the Native families". Their role may involve more advocacy and consulting than providing service roles that will only come about through mutual acceptance, trust and respect. One of the goals will be to reduce the potentiating factors in both the environment and individual which lead, or contribute, to dilemmas.

Culturally Sensitive Health Care

Many implications arise in discussion of providing health care services to Native peoples in general and to childbearing women specifically. For the purposes of this study, the focus is on childbearing women and the implications are confined to three target strategies: primary health care, health promotion and primary prevention, and complementary health care sectors. These three strategies are believed to be relevant to policy

development issues within the Canadian health care system. Taken together they could provide an environment for promoting holistic health and well-being of the family and community. However, such extrapolations to policy development go beyond the present data analysis and careful refining and supplementation of the data would be necessary to enable more accurate health planning for the future.

Native peoples have traditionally taken a holisitic approach to health: one that seeks to promote well-being and prevent illness through the lifestyle behaviours and transactions with the environment. A holistic perspective is consistent with the belief that the body, mind and spirit interact together and with the environment, either in harmony which leads to well-being, or in disharmony which leads to illness. Emotional and spiritual factors and mental outlook seriously affect the physiological workings of the body and cannot be separated in person-environment relationships and outcomes. A holistic approach is a humanistic approach and requires responsible coordination, cooperation and action of many resources, including the individual and family. The three strategies suggested have the potential, if not mandate, to be based on a holistic perspective.

Primary health care is a practical approach to making essential health care accessible to individuals and families in the community with their full participation, in an acceptable and affordable way. Its shape is determined by social goals (e.g. to maximize **health** benefits to all members); these goals are attained by social means (e.g. acceptance of greater responsibility for health by communities, families and individuals). The need for

harmony within the health care sector and with other social and economic sectors is recognized and promoted through primary health care. Primary health care is considered by the World Health Organization to be the key to attaining an acceptable level of health by all, as it contributes to improving health status by stimulating action and organization supporting a community developmental process. There are well-defined elements of primary health care which, developed together, will increase the likelihood of reaching the goal. They include: coordination and support of other societal sectors, community participation, accessible, comprehensive health promotion and primary preventive services, appropriate health technology, health teams which include community health workers and members of the com
munity themselves and cooperation, coordination and use of all health care sectors (Declaration of Alma-Ata, 1978).

The Native peoples are already negotiating with the federal government to gain universal control over health care services. Some bands and tribal councils are trying various models for development and administration of services on their reserve. In the midst of cultural diversity and conflict they are trying to maintain many of the important values of the Native way of life, while making choices from the white middle-class value system. The culture conflict has been accentuated by the goal of maintaining a separate identity, rather than promoting integration. The maintenance of a different value system and separate cultural group has implications for developing primary health care services with the Natives peoples. As one Coast Salish elder stated, "only Indian people can

design systems for Indians. Anything other than that is assimilation."

Some questions that require answers before policies can be developed by either the federal government or the Native peoples are:

1. What are the culturally important values treasured by the Native peoples, ones that they will not (and should not) alter?

2. How do these values affect their orientation to accepting responsibility for health care and their own well-being?

3. Who are the most appropriate members to take leadership in resolving health care issues, recognizing the difference in status among band members, sexes and enfranchised women?

4. What inequalities in the health care system do the Native peoples' encounter?

5. To what extent does difficulty in meeting the basic needs of food, shelter and clothing interfere with seeking health care?

6. Where and when should health policy planning and implementation occur in relation to other social and economic issues? Where should the priorities lie?

7. When should various improvements in the Native community take place? Are there stages to the process? What are the priorities?

8. What information is required for informed decision-making for Native and non-Native policy planners?

Health promotion and primary prevention are essential components in primary health care. However health promotion usually receives low priority in general health policy development and individual concerns. Primary prevention is somewhat more important, but less attention is given to it compared to traditional secondary or tertiary prevention. The Native peoples' approach to illness encourages healthy behaviour throughout the Circle of Life. Teaching about primary prevention occurs at the time of critical events, such as childbearing. Their approach to teaching specific beliefs and practices does not readily lend itself to a health promotion model directed towards the childbearing woman, as this period is seen as a normal part of life, requiring nothing more than healthy living throughout one's life with adherence to specific preventive practices during the pregnancy. It may be more relevant at the time of menarche when the girl is being prepared for womanhood.

In a recent World Health Organization document (W.H.O., 1984) health promotion was described as the process of enabling people to increase control over, and to improve, their health (W.H.O., 1984). Thus, health promotion should involve the Songhees community as a whole in the context of everyday life; it should aim particularly at effective and

concrete public participation; and it should be directed towards actions focussing on the determinants or cause of health and well-being. Incorporating health promotion about life changes into the Native people's perspective on holistic health throughout the Circle of Life is culturally appropriate; but it is a challenge. Culture, income, family life, age, physical ability, traditions and the home and work environments will make certain ways and conditions of living more attractive, feasible and appropriate than others. The challenge to the non-Native professional in the health care system is to assist with the development of policies and services which are attractive, feasible and culturally-appropriate to individual Native bands. To meet the challenge the following questions require answers.

1. From a Native perspective, what are the important beliefs, values and teachings regarding general health promotion? Childbearing health promotion?

2. How and when are these transmitted to the individuals?

3. Where do the supports and strengths come from (individual, family and community) that encourage the practice of health promotion behaviours?

4. What are the environmental, family and personal factors associated with health - depleting behaviours, such as cigarette and alcohol use?

5. How do band members perceive the results associated with health - depleting behaviors?

6. To what extent do the perceptions of self-concept and ethnic identity determine adherence to Native teachings?

7. Where do primary prevention practices, such as prenatal care and immunizations, fit into the Native people's value system?

8. What communication processes are most effective for providing health information, knowledge and skills, such as those required in childbirth preparation?

Health care systems can be conceptualized as having three overlapping, dynamic and complementary sectors (Kleinman, 1980). The popular sector includes self, extended family and friends; the folk sector is comprised of people with special power, knowledge or training in health matters; and the professional sector is comprised of organized healing professionals.

The popular sector functions as the chief source and most immediate determinant of care within the Songhees band. Self-treatment by the individual and family is the first therapeutic intervention resorted to by these peoples. Only if unsuccessful is advice or consultation sought outside the family. Then other Coast Salish peoples, particularly band members with special healing abilities, are consulted. The Coast Salish folk sector comprises a well-established network of healers and helpers throughout South Vancouver Island and extends into Western Washington. The number of Shamen have apparently decreased, but other sources of healing, such as the Shaker Church and Longhouse are very evident. However, the peoples are fearful of

admitting to the use of folk healers and their methods because of misunderstanding and ridicule by the professional sector: a resource that they may still wish to use. The Songhees women hesitated to say anything that might support any stereotypic image of "beach births" or "primitive Native" that health professionals may harbour. Neither did they wish to give anyone grounds for questioning their parenting abilities. Native experiences with removal of children from their homes by non-Natives is neither readily forgotten nor forgiven.

Either in conjunction with seeking folk healing, or following it, the professional sector may be visited for their modern scientific orientation. However, since many of the causes of health and disease, from the Native perspective, are specific to the Native belief system, professional treatments are viewed as inappropriate or with skepticism. When the treatments fail or are disagreed with, healers in the folk sector are again consulted. The professional sector, which includes nurses, is not considered to be a source of teachings for health promotion: although it is sometimes consulted for primary preventive measure.

These findings are consistent with those from other Coast Salish studies (Horn, 1975, Bushnell, 1981). Although the data in this study was not analyzed to determine when and why women entered the professional sector, it could be speculated that the reason(s) would be similar to Horn's (1975) findings. One of the reasons why nurses may not be viewed as a source of teaching for health promotion and primary prevention may be because they do not anticipate, in a culturally sensitive and specific way, the learning

needs of the Native women. They do not take an outreach approach. The Coast Salish women in Horn's study assumed that the nurses would know and understand their needs without having to pose questions themselves. The Songhees women reported asking very few questions, although they indicated a need to know as their trust in the investigator grew. Enquiry, part of the communication process, is influenced by beliefs and attitudes on the parts of both the Native peoples and health care workers. Nurses need to take more initiative in identifying learning needs of Native childbearing woman.

Many questions need to be answered in order to do this successfully. The answers will only be forthcoming when trust and respect between Native and non-Native peoples are established. Even then, there are some beliefs and practices that will not be shared by Native peoples because of their sacredness. In no way should this predetermine a judgment concerning their efficacy. Some appropriate questions to ask in order to asses the implications of these and future research findings are:

1. What factors enter into the Native people's decision to use each of the health care sectors for general health? For the childbearing period?

2. How can the three sectors be better integrated so that coordinated and comprehensive care can be planned?

3. Who are considered acceptable as healers and helpers in each sector?

4. When is it appropriate for Native childbearing women to use each of the health sectors?

5. To what extent are the folk teachings and treatments beneficial, harmless, harmful or controversial? Which ones should be encouraged? Discouraged?

One of the uses of descriptive research should be to translate findings into health care objectives. The different approaches taken in the interpretation of this study's data could, if used appropriately, improve the professionals' understanding of the Native women's beliefs and practices, increase the acceptability of mainstream scientific perinatal and child care to the Coast Salish families, reduce maternal and infant mortality and morbidity and improve the health of families, particularly mothers and their offspring. The goal is to provide an environment within the family and community that supports the positive health-related behaviours of individuals in a way that is culturally appropriate to their beliefs, values and practices. In order to resolve many of the Native health issues, the following objectives need to be met: 1) develop viable Native clinics which are operated and staffed by Native peoples; 2) make existing agencies on or near the reservations culturally relevant; 3) develop inservice training for non-Native health care workers; and 4) utilize a more effective approach to the problem of Native health, whereby holistic health concepts and traditional healers can be utilized.

> If you wish to help a community improve its health you must learn to think like the people of that community. Before asking a group of people to assume new health habits, it is wise to ascertain the existing habits, and how these

> are linked to one another, what functions they perform and what they mean to those who practice them. (Paul, 1969; 2)

Development of Nursing Theory

To some extent, the Coast Salish women of the Songhees band have accepted, at least in part, the scientific basis for health care. However, use of such services was not consistent within and between the women. It appeared to be dependent upon mutual trust and respect between the health care worker(s) and the woman. This was apparent even when the health care worker was of Native birth and employed by the Songhees Band. Incorporation of the Native perspective of health and health care, including cultural beliefs and practices, philosophical and religious views, into a scientific framework would be appropriate to meeting the health care needs of these Native women. The resultant conceptual framework could be used to develop hypotheses to be tested, which in turn could lead to useful propositions for nursing theory and development of a body of scientific and humanistic transcultural nursing knowledge.

Combining nursing and anthropological approaches to research and theory development is advantageous to both disciplines in building their respective bodies of knowledge. Recognizing the contributions of the anthropological, as well as biological, psychological and sociological sciences is critical to the development of a holistic approach: the core of nursing. An anthropological approach contributes to the understanding of environments, such that cultural values, beliefs and attitudes are considered equal, if not paramount, to the physical, social and psychologicial environmental factors

affecting health-related behaviour. No longer can nursing focus entirely upon the individual, exclusive of the cultural and situational context, if the discipline is to reflect social reality, such as that expressed by the Coast Salish peoples. Instead, equal attention must be given to the environment and the transactions that occur between the individual and her environment.

The integrated nursing and anthropological perspective taken in this study was a holistic and cultural context approach to understanding a group of Coast Salish women and their childbearing experiences. It reinforced other research findings i.e. that feelings of wellness and illness are strongly influenced, and primarily determined, by one's cultural background and ethnic identity. The integrated approach also focussed on Native women's development from a longitudinal perspective and included as much as possible their learned and transmitted beliefs and behaviours. In future, an integrated nursing anthropological approach needs to deal with transcultural and comparative perspectives with the objective of identifying childbearing beliefs and behaviours that are culture specific and culture universal. A similar research approach is as salient to any one culture as it is to another.

This study has also demonstrated the contribution that nursing can make to anthropology. Information about a wide range of actual and potential health problems and circumstances were identified, as were verbal and non-verbal patterns of communication people adapted in various contexts of their lifecycle. Such knowledge, combined with that of personal experiences with childbearing women, could

provide means of entry into particular communities for further anthropological study.

A nursing perspective provides anthropologists with a view to health rather than disease and to health promotion rather than treatment. This study has highlighted the need to consider the fit between the individual and her family environment; a recognized focus of anthropology.

Assessment of the person-environment fit and resulting outcomes of wellness and health for individuals, families and communities are culturally-determined. What is generalizable and what is unique among the Native peoples in their cultural determination is unknown. Hypotheses generated from an integrative conceptual framework need to be tested and the findings used to develop propositions for nursing theory.

The relationship of ethnic identity and self-concept to the person-environment fit requires clarification in the development of transcultural nursing knowledge since cultural diversity is seen within and between cultures. A humanistic approach to understanding each culture as a holistic and integrated system is essential if nurses are to develop respect for other ways of life and an appreciation of ethnocentrism, since each culture holds as most sacred its beliefs and values about what is the correct and best way to view humanism.

Values underlie customs and practices and can be used to predict behaviour. Some values, although gleaned from behaviour unrelated to childbearing, were found to be important in understanding childbearing behaviour.

Therefore, it is important for nurses to understand the universalistic importance of values associated with specific life events and to recognize that values, while influenced by new knowledge, in turn influence the seeking of new knowledge.

A number of questions arise regarding the nursing implications of this study. They are based on the findings that 1) the Native women did not perceive nurses as part of their health care system; 2) non-Native professionals and governments had the power to take away their culture; 3) other health care sectors were used as alternatives to, or in conjunction with, the professional sector; 4) health professionals, including nurses, were expected to know what the Native women needed with respect to information; and 5) professional health care therapeutics did not coincide with the Native explanation of the cause of the problem.

1. How do Native peoples perceive the potential role of non-Native nurses in their health care system?

2. How can non-Native nurses be prepared to fit into the role(s) required of them by Native peoples?

3. What needs to be done to encourage Native peoples into the health professions, especially nursing?

4. How can Native people's perceptions of non-Native people's power be altered? To what extent and when can empowerment be encouraged among the Native population?

5. What are the social, political, economic and legal ramifications of encouraging Native self-determination and self-government in health related matters?

6. When is it appropriate for nurses to support cooperation and coordination between the professional sector and the popular and folk sectors in promoting childbearing general lifestyle behaviors?

7. How can nurses establish an outreach practice in anticipation and recognition of specific, but unspoken, needs of the childbearing women and other members of the family?

The implications and questions have significance for the four areas of the nursing discipline: clinical therapeutics, administration, education and research. Each of the considerations that follows could be further stated as hypotheses for testing. However, prior to this further explanatory research on the integrated holisitic model is required to clarify and validate category definition and analysis and establish reliable methods of data collection. Any attempts to use the findings from this study in nursing clinical practice are premature. The findings are specific to the Songhees people. However, in general, within the clinical therapeutic area, nurses need to consider the issues of transcultural communication, outreach programs, liaison with other health care sector practitioners and development of knowledge of practices currently used. Nurse administrators are in a unique position to initiate coordination of all sectors of the health care system, plan for flexibility within their services and nursing personnel to meet the needs of

accessibility and acceptability and participate in policy development that reflects cultural needs. Nursing education provides the opportunity for preparing nurses in both generalities and specifics: general transcultural nursing concepts, as well as unique beliefs, values and practices of a variety of cultures. Integration of this approach is necessary throughout the nursing curriculum, from health promotion to acute care to palliative and rehabilitative care. Education based on research is the goal. As well nurse educators have the responsibility for encouraging and supporting Native peoples to enter the nursing profession.

The scope for nursing research is unlimited. For the purposes of this discussion, implications will be based on the findings of this study and the major fields of nursing which it was intended to address, i.e. environments, individuals and transactions between the two. The long range goals of nursing research need to be aimed at generating hypotheses about categories or classifications of nursing care that can eventually be tested and applied in nursing therapeutics.

Nursing research regarding the supportive and non-supportive factors of environments needs to address the family environment in a more holisitic orientation. Cultural, social, emotional, spiritual and physical qualities and their interactions will demand exploratory, as well as more sophisticated research designs to determine the supportive and non-supportive characteristics in certain contexts. Related to this is the need to study both first and second order change and the role of the family and community in each. Culture specific

characteristics, as well as universals, require indepth research within and between Native bands, tribes and other ethnic groups.

A forum planned by concerned Indian professionals and scholars agreed unanimously that Indian "life themes" are most appropriately reflected through the survival and reigning influence of family patterns in Indian communities (Red Horse, 1980). With respect to the challenge of knowledge building they stipulated that the research focus must shift from questions investigating family pathology to questions investigating family survival within an area of institutional neglect.

Miller (1980) advocates a research paradigm for use in studying the Indian family that is based on their world view. An alternative paradigm to the scientific method would focus on theme of "respect for life", be group oriented rather than focussing on the individual, attend togestalt rather than parts of the whole and be linked to real events over time. The focus would be on family strengths, harmonious qualities with the environment, questions framed by the needs of Native families and research methodology that was entwined with service.
Cross-cultural research in childbearing practices requires first of all an acceptable conceptual framework, then a definition of concepts and categories, followed by valid and reliable tools for measurement. "...it is at this point not at all clear what the categories for cross-cultural and cross-system comparison should be" (Jordon, 1983:6). The medical profession has emphasized physiology and pathophysiology; the nursing profession has identified practices and perceptions as being important variables;

while anthropologists have focussed on Native practitioners and ritual. There does not appear to be a conceptual scheme or framework for the comparative analysis of the ways in which the universal biology of childbearing is mediated and interpreted by culture-specific practices. The Medicine Wheel and its elements offers a holistic framework with process concepts of ethnic identity, education and self-concept. It requires further testing and refinement. The ethnic identity scale, adopted for this study has been subsequently used in other Native populations, suggesting its applicability to understanding ethnicity and behaviour.

The basic datum for comparative studies is the ethnographic report, a generalization at one level of abstraction. Because ethnographic data and concepts are interpreted, operational definitions and interval scale date are necessary (Tatje, 1973). This allows correlations andassociations to be made in a more sensitive manner than merely absent or present.

This study has contributed to content categories that may be linked with other childbearing research. Beyond that, it has also identified process categories that are important to understanding social and cultural behavior. It has provided systematic, baseline detail grounded in the culture concept for the continuing generation of hypotheses and theory. It is difficult to separate, in a given cultural setting, what is physiological necessity and what is sociocultural product (Jordon, 1983). Cross-cultural comparisons using the Medicine Wheel framework would offer a way to shed some light on the issues.

Education and communication are transactional processes that have been identified by this study as concepts essential to understanding human behaviour. The dynamic quality of the processes will require nursing research that includes a multivariate approach to data collection and analysis and that looks at family and community processes and relationships of Native peoples with health care professionals.

Further research is required to understand women's commitment to both traditional and contemporary teachings, and what circumstances lead to high or low commitment. A relationship among self-concept, ethnic identity and level of commitment is suggested by this study. Exploring these relationships is warranted. Understanding women's behavior in childbearing in order to plan and implement appropriate nursing therapeutics of health promotion and disease prevention is one way of decreasing maternal and infant mortality and morbidity. The Family Environment Typology offers a means to do this, but needs to be tested in a variety of contexts and among different Native groups.

Another approach that nursing research could take would be to identify and assess risk factors for maternal and infant morbidity and mortality within certain Native populations. Identification of environmental, personal and mediating factors, their relationships and association with specific outcomes would be useful to developing a primary health care approach. Approaching alcohol use in this way might be more readily acceptable to the community as indicating a need for change by the community rather than focussing on an individual approach which tends to be moralistic or punative. Drinking patterns and recall of behavior appear

to be culture specific. A non-Native orientation to research is not likely to lead to valid or reliable findings.

Any nursing research among the Native peoples will require close attention to the process of gaining entry into their system. Developing trust and respect is only one of the requirements. Negotiating sources and use of the data, having a Native critique of findings and analysis and planning publication are becoming an expected parts of the research process. Refusal to allow research must be respected, but reasons should be sought in the hopes that alternative explanations may be given regarding the usefulness and uses of the information gained. In view of their perspective that culture is lost through sharing, advantages must be real and obvious before Chiefs and Band councils are likely to give permission for the research to be carried out by non-Natives. Some alternative approaches may be to work with a Native health care worker and plan a joint study; participate in health care delivery on the reserve; or establish credibility through other opportunities for working for or with Native peoples, such as in an urban setting; or develop a study that has concrete, Native-related outcomes (e.g. programs, publications)

In addition to the general questions raised in this chapter, the following suggestions relating specifically to nursing research and the childbearing period for Native women have been formulated.

1. Use the integrated Medicine Wheel conceptual framework in research with other groups of Native peoples to

validate the categories, subcategories and their definitions.

2. Investigate the beliefs, values and practices of Native men involved in the childbearing period: both fathers and grandfathers.

3. Compare urban, non-reserve Native women with those living on the reserve with respect to the relationship between ethnic identity, self-concept and commitment to childbearing teachings: i.e. Family Environment Typology.

4. Develop acceptable, culturally-sensitive and reliable instruments to measure family functioning processes, including education and communication, and individual lifestyle behaviours, such as nutrition, smoking and drinking.

5. Establish the validity and reliability of the ethnic identity scale among different Native tribes living on and off reserves.

6. Establish the validity and reliability of the self-esteem scale among different Native populations at different points in the Circle of Life.

7. Evaluate strategies used in Native developed, operated and staffed childbearing programs.

8. Compare the culture specific knowledge about childbearing that Native and non-Native nurses incorporate into their nursing care.

9. Compare the acceptability of childbearing teachings by Native women according to the source of teaching (e.g. professional folk or popular sectors, Native and non-Native), medium of teaching (e.g. class, informal group, home) and timing of teaching (e.g. anticipatory, crisis, rehabilitative).

10. Use the Family Environment Typology to assess and modify environments that encourage commitment to teachings: both traditional and contemporary. Determine the differences between 1) reserve and non-reserve women, 2) those with and without a drinking problem, 3) high and low scoring an the Ethnic Identity and Self-Esteem Scales, and 4) those who observe an participate in Native ceremonies and rituals.

It will only be through additional empirical research that the critical variables of the childbearing period will be identified and the cross-cultural questions answered. The assumption that Native peoples have the capacity to direct their own health care, with access to the necessary information, skills, financial resources and policies, can only be validated with further research and hypotheses development testing.

Research among the Native people

Native peoples are skeptical of previous research and anthropological studies that have been carried out, both an reserves and in urban settings. They are more interested in program and protocal development than basic research. They want something that is immediately translatable into

practical solutions to socio-culturally relevant concerns. Therefore, it is recommended that future research endeavours among the Canadian Native peoples take into consideration:

1. including Native peoples in the planning of all research projects.

2. having the research done by Native peoples where possible, with government and academic researchers providing technical assistance when needed.

3. disseminating research data and reports to the Native peoples at the local level where findings can be useful.

4. developing data collection methods that are culturally sensitive and involving indigenous Community Health Representatives or other Native workers in collection and analysis of data.

5. including Native health boards and community groups at local, tribal and National levels as appropriate.

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APPENDIX A

University of Washington

Childbearing Interview Guidelines

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Guiding questions to be used with native women during initial interviewing encounters (not necessarily in the sequence that might be appropriate for the particular context). Probe questions to be used to clarify, expand description or give greater depth.

Preconception and Conception:

1. How was it that you got pregnant at the time(s) you did?

2. What was important to you when you thought (or think) about getting pregnant?

3. Who taught you about being a woman, being able to get pregnant, or how to prevent pregnancy?

4. What were you taught about this? When did the teaching occur?

5. How did you have to change when you became a woman?

6. What did you (are you planning to) teach your daughter(s)?

Prenatal:

1. What led you to think you were pregnant? How did you feel about it?

2. Who did you tell? And what was their reaction?

3. How did you know for sure that you were pregnant?

4. When you thought, or knew, you were pregnant, did you do anything different?

5. How did you learn about pregnancy? (i.e. when did you learn? from whom?)

6. What did you think was important to do during your pregnancy? What did you do? What do other pregnant women do?

7. How did you know about these things?

8. What might happen if you didn't follow these beliefs? teachings?

9. Was this pregnancy like you thought it would be? Like the others? How was it different? Why?

10. What are important factors to consider when planning for, or having, a baby?

11. If you think something is not right with your pregnancy what should you do? Why?

12. What do you think are the most important issues on this Reserve with respect to having healthy babies and children? Why?

13. Who did you go to during your pregnancy? Why?

Labor and Birth:

1. What was (were) your experience(s) in labor and birth? Who was with you? What did they do? How did you feel?

2. How and what did you learn about labor and birth

3. What teachings did you try to follow? How did they help?

4. What do you think is important at this time to have a healthy baby?

Post Partum:

1. Immediately after birth, what should the parents do?

2. Should the afterbirth or cord be cared for in particular ways? How does this affect the child? How did you learn about this? When?

3. What is important in caring for your baby? How did you learn about this? What did you do?

4. How could you tell if your baby was healthy?

5. How did you feed your baby? Why? Who taught you about this?

Probe Questions in all areas were asked when necessary and related to beliefs, values and practices with respect to diet and nutrition, rest and activity, emotional state, special Native ceremonies or rituals, traditional Native teachings and family involvement. Questions were asked in each of these areas to determine changes occurring in the childbearing state - i.e. how was this different than what you usually do?

General Health Issues:

1. What is important to you in order to be healthy? What do you do?

2. How did you learn about maintaining health? What helps you to do or practice healthy ways?

3. Do you smoke or drink? What were your family's reactions to, or teachings about, thes habits?

4. Did you change any of your health habits during pregnancy? Why? What was the reaction to your family?

Questions used for women experiencing a sickness:

1. What do you think has caused your sickness? Why now? How did you know you were sick?

2. What have you done? Who have you seen? How did you learn about doing this?

3. Who has been helpful when you were sick? How?

4. What did you think would happen with your sickness? treatment?

Strengths:

1. What is it that you do that some people like about you?

2. You show much strength, what do you think has helped to make you a strong woman?

3. What in your Native heritage gives you the courage or strength in difficult situations?

4. What do you hope to be able to teach your daughters, sons, grandchildren?

APPENDIX B

School of Nursing
University of Washington
Seattle, Washington 98105

Study Information Sheet

CHILDBEARING PRACTICES AMONG COAST SALISH INDIANS OF VANCOUVER ISLAND' BRITISH COLUMBIA

Investigator: Heather F. Clarke, Doctoral Candidate, of Nursing, University of Washington
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Introduction

During the past several years I have been a graduate student in the School of Nursing, University of Washington. In partial fulfillment of the Doctoral Degree of Nursing Science requirements, I have chosen to conduct a study on traditional and contemporary childbearing practices among some Coast Salish Indians of Vancouver Island. While I am doing this I will also be teaching Community Health Nursing in the School of Nursing at the University of Victoria.

Purpose

Nursing care to Canadian Indians during pregnancy and childbirth is primarily given by non-Native nurses. These nurses are often unfamiliar with specific and important Native Indian values, especially those related to the childbearing period. It is well-accepted that the childbearing period is very important to the health and well-being of future generations, and that a healthy pregnancy is one of the major ways of providing a better future for our children. The fact that more Indian than non-Indian mothers and babies suffer from health problems during the childbearing years is also well known. Thus, the Native children's future is not as bright as it should be.

The purpose of this study is to gain an understanding of the traditional Coast Salish childbearing beliefs and practices that were important and contributed to the health of the mother and baby, and to learn about the present

practices during pregnancy and childbirth. Nurses should provide meaningful and effective nursing care to mothers and their families to promote healthy pregnancies and infants. Thus, it is important to know both the health habits of women during pregnancy and how the family influences her daily living habits such as: diet, smoking, drinking, activity, and emotional well-being.

The study is intended to describe Coast Salish traditional teachings about childbearing and present beliefs and practices of Native women and men during pregnancy and birth. In addition, the study will explore some of the family relationships important to having a healthy pregnancy and baby.

Benefits

Although participating in the study will not be of immediate benefit to any one individual, the information you contribute may benefit Coast Salish Bands on Vancouver Island and Native Indian health and nursing care services. The study may help to determine ways to improve the health of pregnant mothers and babies and to plan Native-based health education, clinics and services.

Individual identity will be confidential to the study. No one will be identified by name in any reports or papers without their consent.

APPENDIX C

UNIVERSITY OF WASHINGTON

ETHNIC IDENTITY SCALE Code # _ _ _

Instructions for Interviewer:

Listed below are some statements about how one might feel about being of Indian ancestry. Read each statement to the woman and ask her the degree to which she agrees or disagrees with the statement. Circle the letter to the right which best shows how she feels.

Circle A if she strongly agrees
Circle a if she slightly agrees
Circle d if she slightly disagrees
Circle D if she strongly disagrees

There are no right or wrong answers	AGREE		DISAGREE	
1. Anti-Native prejudice is every Indian person's problem even if he/she does not happen to suffer from it.	A	a	d	D
2. Learning about your Indian heritage is not important to anyone who plans to spend his/her life off the reserve.	A	a	d	D
3. Because of their common ethnic background, all Natives should help all other Natives who are in need.	A	a	d	D
4. Native customs and observances mean a great deal to me.	A	a	d	D
5. I would vote for someone because he/she was Native Indian	A	a	d	D
6. I feel more comfortable with other Natives than with non-Natives	A	a	d	D
7. It is better that Native Indians marry only other Native Indians	A	a	d	D
8. I think of myself as more Indian than Canadian	A	a	d	D
9. Being of Indian ancestry carries with it many responsibilities	A	a	d	D
10. There is no longer any reason for Natives to learn their Indian language	A	a	d	D
11. I prefer being treated by Native Indian health care workers	A	a	d	D
12. I would prefer to live on an Indian reserve	A	a	d	D

	AGREE		DISAGREE	
13. I prefer that my friends be Mostly Native Indians	A	a	d	D
14. I prefer attending a Native church or spiritual ceremony	A	a	d	D
15. I have a strong feeling of attachment ot my Band	A	a	d	D

APPENDIX D

UNIVERSITY OF WASHINGTON

SELF-ESTEEM SCALE Code # _ _ _

Instructions for Interviewer:

Some people say that the way people feel about themselves makes a difference in how they use health services. For this reason I'd like to ask you to listen to some sentences that people use in talking about themselves and have you tell me whether you would strongly agree, agree, disagree or strongly disagree with each of them in thinking about yourself.

Check the appropriate column for the woman's response
SA = strongly agrees
A = agrees
D = disagrees
SD = strongly disagrees

	SA	A	D	SD
1. On the whole, I am satisfied with myself.	____	____	____	____
2. At times I think I am no good at all.	____	____	____	____
3. I feel that I have a number of good qualities.	____	____	____	____
4. I am able to do things as well as most other people.	____	____	____	____
5. I feel I do not have much to be proud of.	____	____	____	____
6. I certainly feel useless at times.	____	____	____	____
7. I feel that I am a person of worth, at least on an equal plane with others.	____	____	____	____
8. I wish I could have more respect for myself	____	____	____	____
9. All in all, I am inclined to feel that I'm a failure	____	____	____	____
10. I take a positive attitude toward myself	____	____	____	____
11. I get along with most other people very well.	____	____	____	____
12. I would rate myself very high in my daily work.	____	____	____	____

APPENDIX E

ETHNIC IDENTITY SCALE

Scoring Instructions:

1. General:
   a) Positive statement scored: A=4; a=3; d=2; D=1
      (Items 1,3,4,5,6,7,8,9,11,12,13,14,15)

   b) Negative statment scored: A=1; a=2; d=3; D=4
      (Items 2,10)

   Scored in the direction of the positive ethnic identity
   i.e. the higher the scored, the more positive the ethnic
   identity

2. Okano Scale - 15 items were modified from Okano's 16 item ethnic identity scale for Japanese Americans, to make them relevant to Native Indians of Vancouver Island

   - scored out of 60 (i.e. 15 x 4)

3. Native Value Subscales - based on values/concepts important to Natives

   - scored - addition of raw scores of each item of the subscale

I - Social Relationships - importance of belonging, cohesiveness
   Item 5 - Vote Native
   Item 6 - Comfortable with Natives vs. non-Natives
   7 - Marriage - Native only
   11 - Native health care workers
   13 - Friends Native
   15 - Band attachment
   6 items - possible score = 24

II - Learning - concepts of never being complete; learn everyday, especially from elders, personal responsibility for doing so
   Item 2 - Learning heritage - off reserve
   9 - Ancestry responsibilities
   10 - Learning language
   3 items - possible score = 12

III - Caring for others - concepts of being part of a larger whole, of community and communal living
   Item 1 - Responsibility for prejudice problem
   3 - Help each other
   12 - Preference for reserve living
   3 items - possible score = 12

IV - Tradition - concepts of customs, heritage, uniquess of Natives
Item 4 - Importance of Native customs
8 - Indian vs. Canadian feeling
14 - Native spirituality preference
3 items - possible score = 12

APPENDIX F

SELF-ESTEEM SCALE - ROSENBERG SUBSCALES

Scoring Instructions:

1. General:
   a) Positive statements scored: SA=4; A=3; D=2; SD=1
      (Items 1,3,4,7,10)
   b) Negative statements scored: SA=1; A=2; D=3; SD=4
      (Items 1,5,6,8,9)
   Scored in the direction of the positive self-concept - i.e. the higher the score, the more positive the self-concept and self-esteem.

2. Scale:
   a) First 10 items are Rosenberg's Self-Esteem Scale -
      The total raw score is out of 40 (i.e. 10 x 4)
   b) The last two items are Native generated items considered by informants to be important Native ideas of self-esteem
      The total raw score is out of 8 (i.e. 2 x 4)

   Rosenberg Scoring Subscales (Items 1 - 10 inclusive)

   I - Item 3 - No good qualities
   7 - Worthy as others
   9 - All in all - failure
   - scoring: If 2 or 3 out of 3 score 3 or 4 - score = 2
   If 1 or 0 out of 3 score 3 or 4 - score = 1

   II - Item 4 - Doing things - most people
   5 - Not much - proud
   - scoring: If 1 or 2 out of 2 score 3 or 4 - score = 2
   If 0 is 3 or 4 - score = 1

   III - Item 1 - Whole - satisfied
   - scoring: If score 3 or 4 - score = 2
   If score 1 or 2 - score = 1

   IV - Item 8 - More self respect
   - scoring: If score 3 or 4 - score = 2
   If score 1 or 2 - score = 1

   V - Item 10 - Positive self-attitude
   - scoring - If score 3 or 4 - score = 2
   If score 1 or 2 - score = 1

   VI - Item 2 - At times - no good
   6 - Useless at times
   - scoring - If 1 or 2 scored 3 or 4 - score = 2
   If neither scored 3 or 4 - score = 1

   Total - 10 items in 6 scales (i.e. 6 x 2) - score = 12

APPENDIX G

SELF-ESTEEM SCALE - NATIVE VALUE SUBSCALES

Scoring Instructions:

1. General:
   a) Positive statements scored: SA=4; A=3; D=2; SD=1
      (Items 1,3,4,7,10)
   b) Negative statements scored: SA=1; A=2; D=3; SD=4
      (Items 1,5,6,8,9)
   Scored in the direction of the positive self-concept - i.e. the higher the score, the more positive the self-concept and self-esteem.

2. Native Value Subscale scoring - based on values/concepts important to Natives. Score obtained by adding raw score of each item in the subscale (Items 1-12 inclusive)

   A. On the Whole, in general, basically speaking (concept of wholeness, integration)
      Item 1 - whole - satisfied
      9 - all in all - failure
      10 - positive self-attitude
      12 - daily work - rated high
      possible score = 16

   B. At times, depending, not total (concepts of growth, improvement, relevant to context)
      Item 2 - At times - no good
      3 - Number good qualities
      5 - Not much to be proud
      6 - Useless at times
      8 - More self-respect
      11 - Get along with most
      possible score = 24

   C. Compared to others (concepts of part of a larger whole, comparative but not competitive)
      Item 4 - Do things - most people
      7 - Worthy as others
      possible score = 8

VITA

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