University of Alberta

Health Meanings and Dynamics Among Urban Residing Native Women

by

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A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements of the degree of Master of Nursing

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One of the last teachings of my grandfather was "Pay attention!" I didn't understand what he meant. I know now he was saying that the key to life is sensitivity and that only through developing the capacity of sensitivity to everything will we hear the real message. "Ah dah la pi ah chi" were the words my grandfather used, "Become the essence of work, the being of listening, if you want to be a true human being. Become of work, of listeningness, and you will find the voice of our Mother/Father spirit talking" (Rael & Marlow, 1993, p. 46).

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled *Health Meanings and Dynamics Among Urban Residing Native Women* submitted by *Jennie Laureen Garteig* in partial fulfillment of the requirements for the degree *Master of Nursing*.

Dr. Eileen Jackson

Dr. Marion Allen

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Dedication

To my parents who instilled in me an unquenchable desire for learning.

To my husband for his love, support, and ability to always focus back to the reality of daily living.

And to the women who shared their stories and experiences so that I could learn from them; I have been privileged.

Abstract

Health meanings, in the form of health conceptions, influence health actions and health promotional activities. Using the strategies of in-depth interviewing and participant observation, health meanings are explored among urban Native women. Analysis demonstrates that for the women involved in this study, their primary health conception is an integrated understanding of "health as how you live your life." Blended into the integrated conception are concepts of balance, ideal-self, and shadow-self. The latter two concepts are used as by the women in this study as measures or indicators of health as they question their health in related to their bodies, their actions, their feelings, and their visions or goals. In addition, a number of contexts shape the meaning of health for the research participants. As such, multiple contexts are important considerations in how the women enact their health actions.

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CHAPTER 1: Research Overview

Introduction

Nurses practicing within the theoretical guidelines of the nursing profession assist individuals to attain, regain, or maintain health. In their line of work, nurses carry out a number of activities involving a variety of patient populations. These populations are comprised of numerous racial groups, among them, Native people. The voices of Native people have risen lately over the issues of status for Native women who married off reserve, for land claims, for recognizing their inherent right to the land, and for rejuvenating a culture that has almost vanished due to the influence of European contact, oppression, disease, poverty, discrimination, violence, and migration to urban areas. The latter catalyst is an area that has been explored to some extent in terms of the health issues for Native people living in urban areas (Hagey, 1989; Shah & Farkas, 1985), yet implicit assumptions about what health means guide this exploration. Assumptions about the meaning of health are based primarily on a Western, biomedical conception in which health is correlated with the absence of disease. To a lesser extent, health is viewed within a social perspective so that issues of sanitation, violence, and poverty can be identified as health problems for Native communities (Baker, Findlay, Isbister, & Peekeekoot, 1987; Cook & deMange, 1995; Dickson, 1989).

Native people residing in urban areas comprise a sizeable minority (Shah & Farkas, 1985) and they have many unmet health needs. In the area where I live and work, there is a significant number of Native people both living on reserves surrounding the urban centre, and within the city itself. The major bands in the area are Carrier and Sekani, yet there are also many other nations represented like Cree, and Gitksan. Over time, I have observed many interactions between Native clients and health care professionals - doctors, nurses, physiotherapists, and student nurses. I have come to believe that personal assumptions and

preconceptions about Native clients often hamper effective and empathetic communications. Stereotypes abound, and labelling of clients as non-compliant or lazy or resistant may produce scenarios in which clients are blamed for their situation, their predicament, or their illness (E. M. Jackson, 1993). Also, what is often not considered, or challenged, is the fact that White, Western practices, philosophies, and treatments, which form the basis of the culture of health care, are imposed on the Native population and perpetuated through ideologies of dominance. It is no wonder that some health programs and treatments have questionable success with many Native people. In order to plan and deliver culturally sensitive and appropriate health care, Native people must participate in the process; their cultures must be consulted, respected, and integrated into models of health, wellness, illness, and sickness.

Integrating Native voices is a key point given the present changes that are occurring within our health system and social context. First Nations initiatives for self-government in health programs (McClure, Boulanger, Kaufert, & Forsyth, 1990; Young & Smith, 1992) is proceeding, and action by local governments to move health care (back) into the community is occurring (British Columbia Royal Commission on Health Care and Costs, 1991). "Health for all by the year 2000" is the proclaimed goal of the World Health Organization (World Health Organization, 1981). The operative word is *health*, yet this is a term that has evaded definition. In order that health care systems, health policy, and nursing strategies be appropriate to urban Native peoples, the phenomenon of health from their perspective requires exploration. The cultural study of health is reinforced by the writing of Illich (1976) who states that the meaning of health is relative and that it has cultural definitions based on a group's underlying beliefs and values. Jensen and Allen (1993) also affirm the cultural relativity of health in that "there are no universal norms of health; perceptions vary across individuals and cultures" (p. 220).

Taking the perspective that perceptions of health vary individually and cross-culturally, rather than imposing existing constructs on meanings of health, I set out to follow the anthropological tradition of exploring meanings from the insider perspective, that is, seeking the emic perspective. My intent is to explore the meaning of health not from positions dictated by the power-elite, or health providers, but rather from the perspective of individuals who are dependent on them and who have been denied a voice in the planning and implementing of health plans and programs. One such group is Native women. Native women (through creating life) are seen as the keepers of the culture (Fiske, 1993), and often experience additional challenges within the health care area due to caring for their families and themselves. The majority of current research and literature on Native health is not sex or gender-specific. Yet Native women may indeed have different perspectives and conceptualizations of health due to additional life situations that they encounter.

Oppressions and inequalities variously affect women based on the intersection of race, class, and gender (Brewer, 1993; Wotherspoon & Satzewich, 1993). The work of women has been devalued in that women's work has largely been in the home (domestic work), and men have placed less value on women's work as it does not contribute to capitalist society (Ng, 1988). Native "women's economic contribution to their household and community became marginalized as traditional economies were disrupted and changed" from initial and continued European contacts (Chiste, 1994, p. 28). In other words, the prevalent ideology values work in the public domain that contributes to social production, while little value is placed on work that occurs in the private domain, such as child care and house work. The outcome of this type of ideology is that women's voices have largely been absent from the voices that create, perpetuate, and maintain ideologies. This absence of voice can be translated and applied to the health domain, where the individuals with sanctioned power, that is, physicians, have created

the ideologies that dictate health and illness experiences (Crawford, 1980).

Through description and clarification of health conceptualizations from Native women's perspectives, improved communication may be facilitated. This in turn may help make interventions more appropriate and meaningful as there may be some degree of shared meaning regarding health goals and motives. If nurses are to actively participate in fostering and facilitating the health of Native women, then understanding how health is conceptualized from their perspective is vital to this undertaking. Thus I arrived at my intent to work with Native women who live in an urban centre in order to come to some understanding of what health means to them, and how the contexts of their daily lives are integrated into conceptualizations of health.

In order to set the stage for the proposed research, there are three underlying assumptions that require identification. These assumptions are as follows:

1. Beliefs, values, and attitudes about health (part of how one conceptualizes health) influence health behavior. Conceptualizations of health affect the meaning given to symptoms, and the choices and decisions one makes in relation to health. However, these choices and decisions are constrained by predominant social structures and values as well as available opportunities (actual or perceived).

2. Individuals conceptualize health in different ways. There is no assumption that there is a "universal" conceptualization of health for the population of interest (Native women residing in an urban center). However, exploring conceptualizations of health among this population may provide similarities of themes that may be representative of the cultural meaning of health.

3. The traditional Western medical model for conceptualizing health focusses on the absence of disease. Predominantly, health research has used this biomedical model of health, and the health care system in Canada has been based on this conceptualization. There is a potential for conceptual conflict with cultural groups who do not conceptualize health in the biomedical fashion.

Purpose of the study

Health care systems, policy, and strategies all guide, in some manner, the delivery of nursing services. Exploring the emic perspective of health ought to provide critical direction for health services planning and policy. This exploration among Native women living in an urban area is also essential so that nurses can interact positively with this population group in an authentic, connected, and meaningful manner. A review of the literature has shown that little attention has been given to the health perceptions and conceptualizations of Native peoples themselves. This void of information leads to a cultural gap in non-Native and Native interactions. Urban Native health is deserving of attention and, as health professionals, nurses can learn from the experiences of the people that they serve (Mussell, 1992). Conducting research in the area of urban Native health knowledge can be seen as a strategy for working with individuals for "the common goal of health improvement" (Postl, 1986, p. 254). In order to work with Native women living in an urban center for health improvement, the following research question is posed: What is the meaning (perceptions and conceptualizations) of health for Native women living in an urban center?

Definition of Terms

Native people (and population) includes persons of aboriginal decent living on- or off-reserves, Status Indians, Non-status Indians, Inuit, and Métis. Native in its usage also refers to peoples with First Nation citizenship, identity, heritage or treaty status (McClure et al., 1990). For the purposes of this research, Native is used in application to individuals who identify themselves as Native and is not dependent on treaty status.

Urban Native refers to those individuals whose primary place of residence is within urban areas, that is, they spend more time living in the city than on a reserve. No residency period is established as some of the population is transient in nature, moving back and forth

between the city and their home communities (Royal Commission on Aboriginal Peoples, 1993; Shah & Farkas, 1985). Urban Native people may be either status (registered under the Indian Act), or non-status (non-registered). Approximately 40% of Native people live off-reserve, the remaining 60% live on reserves (McBride & Bobet, 1992). Of the status Native population, 53% reside on-reserve (Health Canada, 1994).

Literature Review

In the literature, the meaning of health has many theoretical and operational definitions. Using key terms such as health, concepts, Native American, and women, a search of the literature listed in CINAHL, PSYCHLIT, and HEALTH PLAN were reviewed for applicable research. Additional sources were sought from on-line listings at the University of Alberta Circumpolar Library (focus on Native people and the North). The literature review is not exhaustive in nature, but rather, select sources have been utilized in relation to the research question and the population of interest. The review begins with an outline of major health needs of the Native population based on epidemiological research, proceeds to literature on health conceptualizations, and then narrows in scope to address health conceptualizations from the traditional Native view. Native women's health is also addressed in this review.

Morbidity and Mortality

Much of the current literature on Native health focusses on the mortality and morbidity indices of Native peoples on reserves (Clark & Kelley, 1992; Musto, 1990; Postl, 1986; Rhoades, Hammond, Welty, Handler, & Amler, 1991; Wilson, Krefting, Sutcliffe & VanBussel, 1992; York, 1989). Morbidity and mortality rates within this population are likened to those of the Third World (Drew, 1992). However, the health of urban Native people, as opposed to reserve Native people, is a relatively unexplored area. In part, this absence of health research can be attributed to the fact that the Medical Services Branch

(Health Canada) maintains records only for status Aboriginal people (Inuit, Native, and Métis). An American study found that health status among urban American Indians and Alaskan Natives was consistently poorer when compared to White people on numerous morbidity and mortality rates (Grossman, Kreiger, Sugarman, & Forquera, 1994). McClure et al. (1990) in their bibliographic review of off-reserve Native health found one theme to be the negative effect of acculturation and adaptation to urban life on the health of Native people. Shah and Farkas (1985) present evidence that urban Native health is similar to reserve Native health, with the addition of stressors of city life and an unfamiliar health care system. Last (1982) believes that the health of urban Natives is actually worse than Natives living on reserves. When combining the factors of unemployment, racism, poor housing, and different communication styles, this belief seems plausible. Farkas and Shah (1986) in a survey of medical officers of health, found that there are indeed unmet needs of urban Native peoples. Health concerns included alcoholism, poor nutrition, and stress. Additional literature recounts the health problems common among on- and off-reserve Natives: poor housing, lack of education, high unemployment, poor sanitation, and lack of water resources (Garro, Roulette, and Whitmore, 1986; Mardiros, 1987).

Results of epidemiological studies demonstrate that the Native population has a high incidence of diabetes, anemia, gallbladder disease, lung disease (e.g., tuberculosis, bronchitis, emphysema), hearing impairment, visual defects, hypertension, and infectious and parasitic disease (Barnes, 1985; Garro, 1988; Musto, 1990; Shah & Farkas, 1985; Statistics Canada, 1993; Young, 1982). Mortality indices reflect high rates of suicide, infant deaths, post-neonatal mortality, accidents, and violent deaths (Barnes, 1985; Muir, 1991; Pekeles, 1988).

In comparison to the aforementioned epidemiological findings, when surveying select Canadian urban Native people, the following health concerns are identified: maternal and

child health, young mother/adolescent pregnancy, tuberculosis and its control, substance abuse, single parent living alone, birth control problems, child neglect, low immunization rates, poor nutrition, and mental health needs associated with poverty, unemployment, and adjustment to urban life (Farkas & Shah, 1986; Large, 1984).

Recounted above are health problems and health needs, yet the meaning of *health* is not made explicit. Rather, the meaning of health is implied by how the authors (and researchers) focus on diseases, illnesses, and decreasing death rates. In these studies, health is seen through its opposites from a medical perspective - illness, disease, and death. In contrast, the health concerns and threats to health identified by Native peoples themselves reveals that health is seen from a social context with many facets. Health needs, health concerns, and threats to health are covered in the literature, yet the meaning of health has many definitions and meanings. What is glaringly absent in the literature is research that explores health from the perspective of Natives themselves, outside the confines of a disease paradigm.

The Phenomenon of Health

Health is a phenomenon that has no clear definition within the profession of nursing (Keller, 1981; Maffrey, 1986; Newman, 1979; Natapoff, 1978; Reynolds, 1988). Morse (1987) writes "this vagueness is disconcerting when health professionals are given the task of promoting and maintaining health, as well as caring for the sick" (p. 27). Although the term health is included as one of the metaparadigm concepts (Fawcett, 1992) there are many meanings found in the literature (Huch, 1991; Jensen & Allen, 1993; Meleis, 1990; Pender, 1990; Simmons, 1989; Smith, 1991). Two major paradigms of health have been identified by Newman (1991), that of the wellness-illness continuum paradigm, and the development paradigm. Implicit in these two paradigms are objective and subjective dimensions. However, the wellness-illness paradigm deals primarily with a scientific perspective in which control,

causality, and prediction of outcomes prevails (Newman, 1991). In opposition, the development paradigm seeks to explore and understand the "patterning of person-environment" through addressing the "dynamic whole of the health experience" (Newman, 1991, p. 222). In Simmons' (1989) concept analysis the following attributes of health were delineated: absence of disease, role performance, adaptation, and maximizing human potential. Smith (1981) has defined four models of health: eudaemonistic, adaptive, role-performance, and clinical models. Smith's four models of health can be seen to form a scale in which the clinical model is the narrowest view, and progresses in complexity to the eudaemonistic model that reflects the broadest view. Jensen and Allen (1994) undertook a meta-analysis of 112 qualitative studies in order to develop theory about health, disease, illness, and wellness. They write that the "process, meaning, and context inherent in the experience of health-disease are described as 'living-in-the-world' of health-disease" (Jensen & Allen, 1994, p. 349).

Few researchers have examined the phenomenon of health from a lay perspective. Morse (1987) explored health from the emic perspective of an inner city population and found that health was viewed as either holistic with a mind-body interaction, or dualistic, with a mind-body split. McKie, Wood, and Gregory (1993) conducted discussion groups with women to elicit self-definitions of health. A major theme of this research was the connection women made between health, food, and diet. Woods et al. (1988) set out to explore the meaning of health for a multi-ethnic population of women by asking the question, "What does health mean to you?" Analysis of responses were compared to Smith's (1981) four dimensional model; results were consistent with the addition of multiple dimensions within the eudaemonistic category. Women reported much diversity in their images of health with an emphasis on the eudaemonistic dimension. Ethnicity and employment status did not significantly influence health images. Natapoff (1978) asked elementary school students the

following questions, "What does the word health mean; How do you feel when you are healthy; How can you tell when a family member is healthy; and Can you be part healthy and part not healthy at the same time?" (p. 996). The respondents in this study saw health as "feeling good and being able to participate in desired activities" (Natapoff, 1978, p. 999).

There is little available literature that documents health perceptions and conceptualizations from an urban Native perspective within a Canadian context. Nanooch (1983) writes that "health to an Indian is the power to exist and to function harmoniously" (p.22). Ross and Ross (1992) expand this statement in that "the spiritual, physical, and psychic health of Natives is inextricably bound to the land" (p. 299). The traditional view of health from a Native perspective is holistic in nature. Health is seen as the balance or harmony of a person's physical, spiritual, mental, and emotional dimensions (Buehler, 1993; Hodgson, 1987; Royal Commission on Aboriginal Peoples, 1992; 1993a; 1993b). In the United States, Sobralske (1985) published work on the perceptions of health from a Navajo Indian perspective. With this group, health is seen as a "state of not being vulnerable to threatening situations" (p. 36). The importance of environment and spirituality are also apparent in the Native perception of health (Nanooch, 1983; Hodgeson, 1987; Royal Commission on Aboriginal Peoples, 1992). Health of Native people cannot be separated from their reality, their contexts, and their daily lives. And trying to explicate Native health from a predominately biomedical model (health as the absence of disease or illness) based on morbidity and mortality provides only a partial picture.

Native Women

Much information in the area of Native health does not separate female from male views, rather is it amalgamated so that the presentation represents the whole group or community (depending on the research). Native women residing in urban centers may have

multiple factors that affect their health (and thus, presumably, how they view health) due to the influence of poverty, discrimination, and heavy child-rearing responsibilities. Native women are four times more likely than non-Native Canadian women to die from accidents and violent deaths (McBride & Bobet, 1992). Native women make up a significant portion of the Native people living in urban areas; an estimated six to 10% more women live off-reserve than men (City of Calgary, 1984; Wotherspoon & Satzewich, 1993). Of those women reinstated into status through Bill C-31[1], between 95 and 98% are residing off-reserve (Health Canada, 1994; McIvor, 1995). A large number (ranging from a reported 16% to 42% for Native families compared to about 9% of non-Native families) of urban Native families are headed by single women (Baker, Findlay, Isbister, & Peekeekoot, 1987; City of Calgary, 1984; Health Canada, 1994; Statistics Canada, 1984; Wotherspoon & Satzewich, 1993). Poverty is pervasive among Native women (Wotherspoon & Satzewich, 1993), and urban Native women represent a high percentage of Native people on government social assistance (City of Calgary, 1984; Fiske, 1993). Native women are younger, have more children, and begin having children earlier than their non-Native counterparts (McBride & Bobet, 1992). Half of Native mothers are under the age of 25 (McBride & Bobet, 1992; Health Canada, 1994) and their fertility rate is almost double that of non-Native women in Canada (Medical Services Branch, 1985). Low utilization of prenatal care (City of Calgary, 1984; Glor, 1987; Woodward & Edouard, 1992), alcohol and tobacco use during pregnancy (Davis, Helgerson, & Waller, 1992; McBride & Bobet, 1992; Robinson, Conry, & Conry, 1987) and delivering low birth weight infants (Muir, 1992; Health Canada, 1994) pose additional health challenges for urban Native women and their children.

Theory and Method

This section gives the reader an overview of the grounding of this research that explores the meaning of health for Native women living in an urban setting. In addition, information regarding qualitative research is included to set the context of the research. Presented discussion includes my positionality[2] within the research environment. After the grounding is reviewed, the method of research is outlined.

Research Grounding

Studying across difference

There are several issues that require delineation at the outset of this section that focus on studying across difference, specifically studying across race and class. In addition, there are three assumptions that link with the issue of studying across difference when exploring the phenomenon of health. The first assumption is that health (subjective perceptions and conceptualizations, as well as the objective measures of health and health status) is influenced by the social context, in that variables such as ideologies, politics, and culture are shaped by those in power, and health in turn is influenced by such factors. In addition, attitudes, beliefs, and perspectives shape individuals' responses to life circumstances. The second assumption is that life circumstances are influenced by social and environmental facts such as unequal distribution of resources, cruelty, exploitation, unequal power relations, and institutional discrimination on the basis of one's gender, race, and class standing. Marilyn Frye (1983) captures this assumption in her writing of oppression:

> The experience of oppressed people is that the living of one's life is confined and shaped by forces and barriers which are not accidental or occasional and hence avoidable, but are systematically related to each other in such a way as to catch one between and among them and restrict or penalize motion in any direction. It is the experience of being caged in: all avenues, in every direction, are blocked or bobby-trapped (p. 40).

The third assumption is that victim-blaming (Bowman, 1993; Crawford, 1977; E. M. Jackson, 1993) results when the influences upon life circumstances go unacknowledged. The effects of social influences on health and health behavior is a cognitive process. Yet this personal cognitive process is situated in society where the interplay between, and among, macro-level issues like ideology, inequality, discrimination, and politics influence behaviors and beliefs. When health is understood as more than simply the absence of disease, the social, political, and economic spheres demand attention and integration into how nurses understand health.

Beginning the research process, I was conscious about being a White researcher entering a study environment of Native people, people who may hold beliefs different from my own, may have different world views, and indeed, may hold different positions in life. The concept of Native can either refer to one's cultural orientation, or refer to one's heritage or race. *Race* is a social category generally defined through physical appearance, as a group of people having certain physical peculiarities in common (Howard, 1993; McCarthy, 1993). Race refers to a group of people traditionally thought of as connected by common decent of origin. Today, there is the mistaken belief that the physical features used for categorizations reflect social, behavioral, intellectual, or physiological difference (Howard, 1993). Traditionally and historically thought to be a discrete biological category, anthropologists have developed cultural meanings. One author describes the current conceptualization of race as "the part of one person's variation on the theme of humanity created by the interplay of geography and inheritance" (Shreeve, 1994, p. 58). Another addresses the impossibility of discrete races and divisions (Murphy, 1989):

> It is impossible to delineate the boundaries of race and equally impossible to list a neat, uniform catalogue of the traits of any race. Scientifically, our popular racial classifications make as much sense as would a taxonomy of black-haired dogs, brown-haired dogs, and white-haired dogs (p. 19).

This statement reflects the insignificance of race scientifically, yet the relevance of race as a socio-cultural concept cannot be denied, as race is a symbol of non-biological difference (Howard, 1993). In other words, even though race is seen as being an inefficient and inaccurate means of exploring human diversity (Lieberman & Jackson, 1995) the construct has meaning, in application, as people frequently mark difference based on visible physical attributes.

Race is a social construct (Cohen, 1993; Jackson, 1993) and because of this, race is a fluid category that reflects power relationships within a given society. Political struggles can influence, and indeed transform, social categories (Alcoff, 1988) and given this reality, racial definitions can be reproduced through collective action (McCarthy, 1993). Racial identity is often framed on difference, reverting to a dualist perspective. "'What is not' defines the boundaries of 'what is', who is the same as I am, who is other, and according to what criteria?" (Cohen, 1993, p. 292). Race is, above all, a marker of difference (Frankenburg, 1993) in that individuals are categorized based on the perception of color (Gould, 1992). Difference may connotate not equal, better/worse, or having more/less access to resources, yet difference is constructed in context (Cohen, 1993).

Racism encompasses societal beliefs, assumptions, and practices that produce oppressions, inequality, and differential treatment based on one's race (Howard, 1993; Kottak, 1994; Krieger & Fee, 1994). What is salient here is the fact that race is often viewed simply in terms of physical characteristics, and as such, racism becomes the discrimination of a group founded on an assumed biological basis (Kottak, 1994). Individuals encounter prejudice, hatred, contempt, and discrimination based on how they appear; their physical presence to another (Todorov, 1993). One may be visibly a Native person, or visibly Hispanic as viewed by the predominant racial group (in North America, this is the White population). But persons

lacking those identifiable visible markers even though they may be Native by blood and heritage, in all likelihood, will not encounter the same degree of racism as their visible Other. Dominguez (1994) explains this through the fact that there is an "overvaluing [of] particular bodily differences by imbuing them with lasting meaning of social, political, cultural, economic, even psychological significance" (p. 334).

Furthermore, the complexity of racism can be context and situational dependent. Several examples from my fieldnotes reflect the complexity of race as a social category and underscore that race is often simplified into a subjective label based on one's outward appearance.

> Entry: A teacher talks of one student and shares with me this student's struggles with her peer group. The girl "appears" white based on her outward appearance, yet her heritage is Native. This discrepancy between appearance and heritage has lead to her being rejected by her "white" friends because they see her as "Indian" (this is how she defines herself), and she is also rejected by her Native peer group as she does not "appear" to be Native; that is, she is not dark skinned and dark eyed.

> Entry: Salient themes in student presentations of "My Nationhood" were that the "old days" were better, the influence of alcohol and disease brought by the "White people" (only one used the term European in her presentation), and trying to reclaim their culture. I was very conscious of being a "White" person, of being a descendant of those that controlled and exploited Native people through generations of colonization. I think that it's nine generations on my father's side and five on my mother's side.

The latter entry also typifies conscientization, that is, a personalization of the tribulations that multiply oppressed individuals and groups can encounter at the hands of the oppressor(s). Sieng and Thompson (1992) exemplify conscientization with Khmer women refugees in their words "I felt a profound sense of personal and collective responsibility for their displacement. This is the personal and political kind of consciousness that women of color have insisted that we [White feminist practitioners and academicians] must confront" (p. 134).

Studying across race, for me, is a reality that required examination and constant reflection so that I was not stereotyping and labelling based on my own past socialization to certain categories. The other reality is recognizing that "racial categorization in everyday life is usually overly simplistic" (Stanfield, 1993, p. 17), and for me, this meant not reducing race to one's heritage, or correlating race with culture, but rather developing an awareness of the permeance of race in everyday life, in the formation of self-definitions, and in the concepts of others (Stanfield, 1993).

Another reality confronting me is studying across class as well as across race. Class membership orders the social strata in regards to power relationships. Because North America is a capitalist society, those with higher income, higher education, and larger access to consumption and production of resources are promoted to higher class membership. Within a Canadian context, class is usually defined by the combined variables of education, income, and occupational status. In effect, class status has been transposed into a measure of socio-economic status (Sev'er, Isajiw, & Driedger, 1993). Class structure can also be conceptualized in terms of the ownership or control of three productive assets: cap al, organizational structure, and skills or expertise (Western & Wright, 1994). Class location has been predominately defined by the class standing of the husband, translated into the head of the household (Baxter, 1994). Criticisms of this approach relate to the undervaluing of women in relation to family status, and the increased difficulty in defining family, let alone head of household; the unequal opportunities afforded women to contribute to the family, that is the gendered and classed experiences of women in relation to class standing; and the inattention to the role of unpaid work in the home as it affects the ability of women to enter the labour market (Baxter, 1994).

Based on these outlined criticisms, and in attempts to incorporate the subjectivity of class, I refer to class as one's subjective understanding of placement in the world, of a consciousness of one's position in relation to others that incorporates both power and economics (Urciuoli, 1993). Relationships with potential research participants could be complicated by the social distancing often mandated through class differences (Andersen, 1993; Ostrander, 1993). In order to mediate this potential for social distancing, engagement in the lives of the research participants is essential. In effect, involvement in the lives of research participants is a means of "world travelling" (Lugones, 1992) in attempts to understand others as subjects and not objects.

> The reason why I think travelling to someone's "world" is a way of identifying with them is because by travelling to their "world" we can understand *what it is to be them and what it is to be ourselves in their eyes* [original emphasis]. Only when we have travelled to each other's "worlds" are we fully subjects to each other...without knowing the other "world" one does not know the other, and without knowing the other, one is really alone in the other's presence because the other is only dimly present to one (Lugones, 1992, p. 288).

In addition, focussing on the daily lives of the research participants is a mechanism that can consciously prevent me from reconstituting the Other as an "exotic in danger of being disempowered by that exoticism" (Mascia-Lees, Sharpe, & Cohen, 1989, p. 30).

Knowledge and Knowing

The method of research I employed is viewed as interpretive, and recognizes the active role of the researcher, as well as the importance of context in shaping meaning (Lowenburg, 1993). Everyday life is seen as complex, meaningful, and having multiple interpretations. Contradictions can be accepted and incorporated into understanding when multiple interpretations are assumed to be relevant. Reflexivity[3] is viewed as valuable and critical, especially in relation to how I interact and communicate with research participants considering "power and status inequities" (Lowenburg, 1993). To put this another way, "the research

process must be seen as socially constructing a world or worlds, with the researcher included in, rather than outside, the body of their own research" (Steier, 1992, p. 2). Through this inclusion process, research becomes spiral in nature with the researcher examining how she is part of the research, and how her roles in the research shape the construction of meanings.

Within a broader understanding, knowledge is viewed as context dependent and relative with phenomenon such as health having "multiple, interrelated parts in relation to a specific context" (Newman, Sime, & Corcoran-Perry, 1991, p. 4). This perspective allows the researcher to value both contexts and subjectivity (Campbell & Bunting, 1991), so that in exploring meaning through voices and stories of research participants both micro-level and macro-level influences are recognized (Anderson, 1985).

Culture and Emic-Etic

The concepts of culture and emic-etic also ground this research. Exploring the meaning of these concepts provided an additional position from which to gather and analyze data. Culture is somewhat of an ambiguous term for those uninitiated into the anthropological field. Even within the field of anthropology there is no universal definition of culture (LeVine, 1984). The meaning of culture can be divided into two different philosophical camps: materialists and idealists (Barclay, 1986). Taking the former view of materialists, culture is primarily based on behaviour, and the products of behavior in the form of material objects. Taking the latter view of idealists, culture exists in a person's head in the form of ideas. The meaning of culture has themes such as being learned, and being acquired knowledge; knowledge and learning form the basis upon which people interpret experiences and formulate behaviours (Spradley & McCurdy, 1994). According to Spiro (1984), culture consists of normative and descriptive propositions that reflect a cognitive system, and these cultural propositions are traditional and collective. Examining cultural propositions may entail

exploring ideas, beliefs, personal knowledge, and such things as meanings that certain symbols, myths, and metaphors have for individuals. For the purposes of this research, culture is viewed as a cognitive system of meanings that shape and mediate experience, as well as provide interpretation context.

Linked with the concept of culture are the terms emic and etic. An emic perspective is the research participants' perceptions of their lived world, whereas an etic view reflects the researcher's or scientific perspective of reality (Boyle, 1994). The two terms emic and etic dichotomize reality based on the who is seen to be the knower, and who has legitimate knowledge to be shared (read: valued). Valuing an emic perspective requires that the researcher accept, document, and incorporate multiple perspectives of reality (Hardin, 1991). In this study, both emic and etic perspectives are incorporated. Data are generated primarily through informant interviews, yet my frame of reference and field notes are used, in part, to add to the data collection. Interpretation of the phenomenon of health meaning is inclusive of both emic and etic and shades of the two. For the research participants, my interpretations are partly etic as their words and stories have been filtered through me. Yet from my perspective, interpretations include two emic views: my views, and the views of the research participants.

Qualitative Research

According to Morse (1992a), qualitative research has three key features: a) an emic perspective, b) a holistic perspective, and c) an inductive and interactive process of inquiry. Emic perspective has been addressed above, and involves data collection from the perspective of the research informant or participant. A holistic perspective requires that the researcher attend to the whole, the entirety of the phenomenon under study so that factors such as context, values, and beliefs are considered in the research process. Inductive and interactive

reflects a spiral of meaning-making that moves through incorporating multiple perspectives to encompass the inherent complexity of phenomena.

Implicit in any research method are assumptions. Assumptions provide the structure for answering questions about the nature of reality, the researcher-informant relationship, and truth statements (Haase & Myers, 1988). Applying these questions to qualitative research provides the following structure for research. First, on the nature of reality, valuing an emic perspective validates multiple realities and renders subjective experiences legitimate (Haase & Myers, 1988). Second, the relationship between researcher and those being researched is one of connected-ness, immersion, and valuing. In this research, one example of valuing is reflected in the language I use, such as referring to the women involved with the research as research participants, rather than informants or subjects. Indeed, the researcher's "self" is also a important tool for data collection (Lipson, 1989), thus the relationship of the researcher to the research process requires attention through such routes as reflexivity. In addition, interweaving the issues of studying across race and class may also provide fruitful insights into meaning and understanding, so that micro and macro-level contexts can be incorporated into the research (Hinds, Chaves, & Cypress, 1992). Third, truth statements in qualitative research are set against a backdrop of a world that is continually changing, continually in flux (Haase & Myers, 1988). In bringing this statement to a more pragmatic level, McBride and McBride (1981) write that "women live out their lives embedded in a context that may be constantly in flux...no single point of view about women's health can ever be expected to emerge" (p. 47).

Research Method

There is a paucity of information regarding the conceptualizations of health among Native women residing in urban centers. Furthermore, the nature of the research question being posed, namely its relation to thoughts, feelings, and perceptions that are culturally

influenced, supports using qualitative inquiry as the method of research (Field & Morse, 1985). The research is exploratory-descriptive in nature. Ethnographic strategies are used, and these lend a certain interpretive dimension to the research. The research cannot be categorized as a holistic or classical ethnography (Boyle, 1994) as there was not total immersion in the field. formal observations did not constitute a major data collection procedure, and the research goal was not describing an entire cultural system. The foundations of ethnography are grounded in anthropology where the goal is to describe cultural behavior. Ethnography can be defined as study of "lifeways or particular patterns of a culture (or subculture) in order to grasp the lifeways or patterns of the people in their familiar environment" (Leininger, 1985, p. 35). In effect, ethnography seeks to expose stories of everyday life (Aamondt, 1982). It is through ethnography that cultural health knowledge and practices can be discovered (Robertson & Boyle, 1984). Ethnographic strategies are used in order to uncover and explore the knowledge individuals have, and are using, to organize their behavior (Field, 1983). In summary, ethnographic strategies and premises are appropriate as the researcher seeks to discover the cultural meaning of health through exploring health conceptualization(s).

In addition, the following principles guide the process of research:

1. The population of interest is Native women living in an urban center, and the intent is to "give voice" to the women in the research project so as to communicate their reality, as shown through their daily lives.

2. Personal experience and knowledge of research participants are used to guide the research process (Hall & Stevens, 1991).

3. The researcher is committed to incorporating the diversity of women's experiences, their struggles, as well as capturing the context of women's experiences (Thompson, 1991).

4. The researcher is committed to fostering an atmosphere of mutual respect, trust, and equality in relationships.

Data Collecting Procedures

The strategies of participant observation and in-depth interviewing were used for data collection. Participant observation is a means of observing behavior (actions and interactions) in the natural context in which the behavior occurs (Leininger, 1985). Pearsall (1965) outlines four roles of participant observation in which the researcher is involved to a larger, or lesser, extent with the informants. I acted more in the role of participant with some incidental observation. Formalized participant observation did not materialize as originally planned. This occurred for several reasons, among the n the fact that I became involved with another facet of the agency's (see Chapter 2) programming where education is the primary focus, not health; and because I perceived little opportunity existing for observing health-related activities in the classroom environment. In fact, most field recordings reflected more my own reactions to and insights about events, situations, and Native culture as gained through participation activities. To some extent, field recordings form the basis for reflexivity of the research as the knowledge that I gained through participation became incorporated into my frame of reference, and provided insights into how meanings evolve from experiences.

Interviewing

The primary data collection strategy used in this research is that of in-depth interviewing. Interviewing is a direct means of obtaining information regarding beliefs and perceptions (Pearsall, 1965) as the method "takes us into the mental world of the individual" (McCraken, 1988, p. 9). In addition, it is an efficient way of gathering large amounts of data in short periods of time (Marshall & Rossman, 1989). Interviews provide the richness of communication - both from a verbal and non-verbal perspective (Lobionda-Wood & Haber, 1990). Interviewing using an ethnographic foundation allows for an open-ended format in which a "process" (Field & Morse, 1985) evolves from general to specific information seeking.

Open-ended interviewing is necessary in this research as little is known about the area of urban Native women's health conceptualization(s); there is little available knowledge to structure the interview other than focussing on the meaning of health. An open format encourages discovery and exploration in an interactive manner between research participant and researcher.

Research participants were interviewed from one to five times, and interviewing time ranged from thirty minutes to three hours. The interviews occurred in a private space at the Centre, usually in a vacant classroom. Interviews were tape recorded and later transcribed verbatim. In addition, fieldnotes were recorded after each interview about salient non-verbal behaviors, and conversations that occurred prior to, or after, tape recording. Informal conversations with research participants were also recorded as fieldnotes. I originally had some reluctance entering the interviewing process as I felt that interviewing across race may hamper communication. However, from my perspective, this initial reluctance was unfounded once I began interviewing. Waldram (1989) validates my experience; in his research he found respondent reactions did not differ between Native and non-Native interviewers.

Guiding questions were used to focus the interview on the topic of health and health conceptualization(s) (see Appendix A). In effect, guiding questions became "planned prompts" (McCraken, 1988) that moved the interview along by providing opportunity to discuss topics that did not spontaneously emerge in the discourse. I anticipated that open-ended questions may elicit only short answers, or non-committed responses, so research participants were encouraged to relate information through story-telling or exemplars. Nemetz (1980) writes that "in ethnic groups where folk medicine is practiced, the telling of a story has a social message and is an indirect way of teaching" (p. 5). Sandelowski (1991) speaks of narratives as a way of telling stories that capture the personal and cultural experience; narratives are mechanisms

of translating knowing into telling. Telling stories may be viewed as a natural part of everyday life (Stevens, Hall & Meleis, 1992), and as such, may provide much insight into conceptualizations of health through transmission of cultural beliefs, values, and experiences. Non-directive approaches were used at times to engage the research participant. Some level of reluctance to interact with me may have been based on a cultural emphasis in communication of discrete and respectful interaction, and more listening than speaking (Clark & Kelley, 1992).

Although guiding questions were used initially to focus the interview and extract knowledge in relation to health, the majority of the interviews were unstructured in nature. This approach allowed the research participant to direct the tone and movement of the interview according to their needs, directives, or current issues. Ostrander (1993) used this strategy in interviewing across class as she found this fostered rapport and "I would listen and ask the kinds of questions that helped them clarify their own thoughts and feelings" (p. 22). McCraken (1988) further validates a relatively unstructured interview approach by stating that "testimony [should] be elicited in as unobtrusive, non-directive manner as possible" (p. 21). In retrospect, I wonder about the wisdom of using an unstructured format, as there was not a narrowing of focus over time. What the unstructured format did allow though, was discussion and insight into the complexity of the women's lives as they shared about their relationships, social realities, and daily life challenges.

At times I would redirect the interview in attempts to reground back to a health focus. Yet this strategy was not always successful and often the research participant would carry on with her previous line of discourse. Following with the topic of discourse set by the research participant was fruitful in gaining insight into the dynamics around health meaning, and how macro-level variables and characteristics can influence thoughts and behaviours. Once a topic is raised, McCraken (1988) believes that the research participant must be allowed "to go"

wherever she wishes. This freedom is essential as the researcher cannot evaluate in advance if and how the discourse relates to the topic at hand. Another perspective on letting the research participant go where they choose is that this can be a method of catharsis for the individual. "Catharsis is expressing personal feelings, thoughts, and problems" (Hutchinson, Wilson, & Wilson, 1994, p. 162) and has been noted as a major benefit described by research participants in qualitative studies (Hutchinson, Wilson, & Wilson, 1994). These authors go on to describe other benefits of interviewing such as self-acknowledgement, sense of purpose, self-awareness, empowerment, and healing, and providing a voice for the disenfranchised.

Using an unstructured format reinforced my placement as learner in the relationship dyad, and reflected giving voice to the research participants. These two situations in fact provided the opportunity for me to operationalize guiding principles in this research; a change occurred in the relative power between myself and those that were interviewed. Mishler (1986) speaks of an empowering research reality where interviewing is seen as a form of discourse. Assuming this perspective allows freedom of individuality in interviewing "to facilitate respondents' efforts to construct meaning from their experiences, develop fuller and more adequate understanding of their own interests, and act more effectively to achieve their purposes" (Mishler, 1986, p. 135).

What is very obvious to me now, after being removed from the interviewing process, is that I was in an active state of learning about how to interview based on assumptions and beliefs I hold about the researcher-researched relationship. I began the first interview with each new research participant in the same manner. After setting up the tape recorder, the research participant and I reviewed the consent together and clarification and reinforcement was given as necessary. After the consent to participate was signed, I asked biographical questions after providing a short explanation as to why I viewed these questions as important.

After biographic questions were completed, the tape recorder was turned on. With the first two research participants, I began the interview by asking directly about health meaning. With successive research participants, I changed tactics and engaged the participant in discussion about themselves first before moving into the health related area of questioning. This change in approach at the beginning of the interview helped to extend "face-safety" (McCraken, 1988) beyond the first questions seeking biographical information into the beginnings of the tape-recorded interview. Face-safety may have taken longer to establish with the women that I interviewed due to scepticism of my genuineness, and needing a period of time to "check-out" (Ostrander, 1993). Asking questions about individual women's personal contexts afforded the ability for the research participant to establish defenses and set boundaries on what was shared with me (McCraken, 1988), as well as demonstrating my interest in them as people, not simply research subjects, what Hall & Stevens (1991) refer to as exploring "the perspective of their own experiences, as they understand themselves and the world around them" (p. 17). In addition, I was beginning to learn from the initial interviews that health is inseparable from life, and as such, discourse about daily life was essential to gaining a full understanding of health meanings and move beyond simple health definitions.

Introduction to Research Participants

In this study, six women were interviewed for a total of eighteen formal interviews. Informal conversations supplemented the more formal interviews. Five of the six women are the nucleus of the study, as I had repeated contact with them and deep data was obtained. For the other research participant, she was interviewed once and her stories are incorporated into the final chapter.

The women who participated in the study were gained through a convenience sampling method. In some regards, my decisions about who to approach for involvement was based on

my relationship with the individual women, as well as my understanding about the type of information that they could share. These guidelines could be correlated with aspects of purposeful sampling in which research participants are selected according to their knowledge of the research topic (Morse, 1989). My original contact with five of the six women was from my first tangible volunteer activity at the Native community agency that I had chosen to use to access potential research participants (thereafter referred to as the Centre). The sixth participant I met through other volunteer activities in one of Centre's educational programs.

Sampling was determined to be complete when I heard repetition of content in relation to health discourse. After interviewing the sixth woman, I heard repetition of data in answer to the question "What does health mean?" By this point in time, some analysis had occurred, and the importance of contexts and experience had surfaced; I knew that it was not possible to have repetition in this type of data due to individuality of the research participants. Additional sampling was also constrained by the timing of this research. With educational programs winding down for the summer, and student attendance dropping, the potential for available research participants became limited.

The six women in this study are self-identified Native women, and are all involved in either attending or working in programs offered through the educational division of the Centre. At the outset, inclusion criteria for research participants were as follows: a) self-identified as being Native, b) woman of Carrier decent, c) residing in the city, and d) over the age of nineteen. A willingness on the part of the woman to talk about her experiences and share her stories are also critical inclusion criteria. A specific time frame of residency is not established as an inclusion criteria due to the transient nature of the urban Native population (Shah & Farkas, 1985). After several months at the Centre, I found that limiting inclusion based on Carrier status was problematic, as many of the women that I met were not of Carrier heritage.

My reasoning for the Carrier inclusion criterion was based on information that I received from one contact person at the Centre, who felt that a large number of people attending programs at the Centre were of Carrier decent. Based on initial observations once I was in the Centre, the Carrier heritage criterion was lifted, and my scope broadened to simply include urban Native women. The decision to remove the restriction of similar heritage meant that the group was more heterogenous in relation to Native heritage. Yet, through the interviewing process, what I found to be salient was not the prominence of their heritage as limited to band affiliation, but rather the shared definition of being a Native woman living in a predominantly White society (and culture).

Biographic data were collected from each research participant at the beginning of the first interview. Specifics of this information are not included in order to maintain some degree of anonymity due to the small number of women in this study. The Native women who participated in this study ranged in age from seventeen to forty-one, and had anywhere from zero to five children. The youngest participant was approached to participate due to her Carrier ancestry, before I lifted that inclusion criteria. All but one have lived primarily within an urban environment, only spending short periods of times either living on or visiting Native reserves. One woman has lived on-reserve for the first seventeen years of her life, and after moving off, has lived twenty years in cities. Of the three currently partnered women, one is married to a non-Native man, and the other two are partnered with Native men. Two other women have been partnered in the past with Native men. Five of the six women are status ive people[4]. Five of the six women were "brought up Catholic", the other was raised in a Pentecostal home. Currently, one woman explains that she prays to the Great Spirit (not God), another states that her religion is "practicing Native spirituality", and the other four define themselves as not practicing any specific religion. The women participating in the research are

representative of a variety of Native heritages including Cree, Carrier, and Nisga'a.

Through ongoing relationships with the women participants, additional information was learned about their personal histories and backgrounds. Of the six women, all but the youngest have recurrent, chronic health problems (including asthma, chronic gallbladder problems, obesity, and stomach ulcers). Four of the six women are living on governmental assistance, in that they are either collecting social assistance (welfare) or unemployment insurance. All of the women, at some time in their lives, have been dependent on governmental assistance as their primary means of income, and as such, all have experiences of poverty in their past. Several continue to live in poverty. Three of the women who are, or have been married disclosed that they have been partnered with abusive spouses.

Overview of Data Analysis

Using ethnographic strategies (primarily interviewing), the intent of the research was to gain a beginning description of the meaning of health. Health meaning is not confined to definitions of health, but includes conceptions, experiences, and dynamics around health. Interviews were tape recorded and transcribed verbatim onto a personal computer, and then made into hard copy. After initial transcription, I replayed the taped interview to check it against the hard copy of transcription. I dwelled with the data by reading and re-reading transcripts (Hardin, 1991). The intent of this dwelling period was to become intimate with the data (Hammersely & Atkinson, 1983).

Analysis of data occurred in phases, and reflected a movement from emic to etic so that with each phase of analysis, the amount and degree of interpretation that I was doing increased. Interviews themselves constitute the first phase. In the second phase, I looked for similarities amongst the stories that women told when examining their whole narratives as put forward in interviewing. Through this review, I found that four general content areas of

discussion emerged: personal context, social and cultural context, health meaning, and health problems. Experiences, concerns, and perspectives within these four content areas were the basis for most of the narrative discourse. This step of analysis was aimed at reflecting the reality of women's lives, and not simply reducing interviews to extract health-related data. The intent was to purposefully avoid "context-stripping" (Mishler, 1986) so that the individuality of each woman's experiences is documented.

The third phase of analysis was to extract health-related data out and collect this in a tabular form, separate from the intact interviews. What data were extracted was based either on the response of the research participants, or on the question(s) that was asked. This data was then reviewed for "key words" based on a form of domain analysis (Spradley, 1979). These key words were then collapsed into similar domains, more of an over-riding meaning. An example is taking key words such as "ulcers" and "varicose veins" and putting these terms under a more general domain such as "health problems." This strategy was done separately for each of the six research participants. The domains generated for each research participant were then assessed for cross-case similarities, looking for patterns that can play a crucial role in achieving knowledge (Yin, 1994). In effect, this strategy could be seen as a method of triangulating various perspectives of research participants (Lowenburg, 1993) using the language of the participants to engage the phenomena through exploring its intersubjective meaning (Wolfer, 1993). What emerged at this stage of analysis were four patterns of meaning: responding, surviving, healing, and good/bad medicine. Several of the patterns of meaning had meaning threads. These meaning threads can be thought of as major content areas within an inclusive pattern of meaning. Meaning threads help to further expand and explain the patterns of meaning. Patterns of meaning reflect a process of making linkages between domains that encompass certain concepts and "noting regularities that arouse the

researcher curiosity" (Miles, 1983, p. 126).

The fourth phase of analysis was to reduce the data being analyzed even further and focus specifically on the data that answer the question: What does health mean? Data segments addressing this specific question were arranged in tabular form and categories and themes were developed. A category captures the essence of the data segment, and a theme is more inclusive, including several categories. Using an integrative perspective, themes were viewed as encompassing "who you are" and "what you do". Combining these two themes, health is viewed as "how you live your life." This phase was necessarily completed last in order that a broader understanding of health could be achieved, and the voices of the women who participated could be preserved to a large extent. It is through this process of analysis that a picture of health meaning emerges that is context-laden and based in everyday living. Health as "how you live your life" is the central concept, and the patterns of meaning, as well as personal, social, and cultural contexts become mediating lenses for health action as well as perceptions of individual health.

In sum, using several strategies of analysis provided the opportunity for not only systematic examination of the research data, but also fostered the determining of parts, and how relationships of the parts can fit into a whole. Examining contexts at the beginning allowed for insight into how context can be constitutive of meaning (Lowenburg, 1993), and as such, contextualizing is seen as fundamental when exploring health meaning. In developing the patterns of meaning, I was in fact, reconstructing meaning based on the research data and the explicated understanding that identified personal, social, and cultural contexts shape meaning. And then analyzing health conceptualization last through the talk of the research participants provides the centrality of health thought within multiple contexts that mediate perception and meanings.

Research Rigor

Qualitative research is centered in the study of phenomena from an emic perspective within a natural setting (Field & Morse, 1985). There is no controlling of variables, no search for causality, and no experimental versus control groups. Because of the (perceived) lack of scientific (read: controlled) grounding, qualitative research continues to be challenged on research rigor. Various authors address the issue of research rigor in qualitative research through such avenues as assessing and integrating validity and reliability in the research process (Dreher, 1994; Hinds, Scandrett-Hinden, & McAuley, 1990; LeCompte & Goetz, 1982; Robertson & Boyle, 1984; Rosenthal, 1989; Rosenbaum, 1988). However, other authors dispute that positivist-empiricist criteria can be applied to qualitative research (Leininger, 1994; Marshall & Rossman, 1989; Sandelowski, 1986). Yonge and Stewin (1988) put this pointedly in saying that "it is difficult to understand why terms associated with measurement theory would be used to describe research that is embedded in rather than removed from context" (p. 62). Yet another researcher and scholar addresses the concern of language in research:

> In the literature on reliability and validity, I found the terminology execrable! We have so many terms to cover the same concept. Nobody is talking to anybody. Anybody who does anything at all on reliability and validity makes up a new term to cover what has previously be discussed in another setting and in another field (Brink, 1989, p. 149).

Without becoming too entangled in the language, the issue of research rigor does require attention. I have chosen to use the concept of adequacy to structure discussion about rigor. I have chosen this concept because according to Hall and Stevens (1991), adequacy encompasses issues of reliability and validity and implies "that research processes and outcomes are well grounded, cogent, justifiable, relevant, and meaningful" (p. 20), thus the spirit of naturalist inquiry is maintained. The subcategories of adequacy will each be addressed in turn: reflexivity, credibility, rapport, coherence, complexity, consensus,

relevance, honesty and mutuality, and naming (Hall & Stevens, 1991).

Reflexivity has been incorporated into the research process by personal examination of my positionality, that is, personal values, beliefs, assumptions, and perspectives that develop through one's positions in life (Alcoff, 1988), and its effect on both the process of research, and my interactions with research participants. A main strategy used for reflexivity was keeping a personal journal that documented my feelings, in which I explored how reality is jointly constructed through personal interactions. It is my belief that research neutrality is a myth, and as such, research bias needs to be articulated in some manner. Thus, personal journalling is also a means through which bias can be examined, fitting with the criteria of credibility (research truthfulness) that Sandelowski (1986) puts forward. A second strategy that was helpful in this regard was in-depth reading about the "simultaneity of oppressions" (Brewer, 1993); this being a means of sensitizing me to potential issues that can arise when studying across race and class.

Credibility is "the construction of credible descriptions and explanations of women's experiences that can be understood by both insiders and outsiders" (Hall & Stevens, 1991, p. 21). In this research, descriptions and explanations flow primarily from the words and voices of the research participants, through me, and into some (what I see as) meaningful presentation. Yet the words of the participants are the focal point and become the foundation for further interpretive work that I construct. One method to foster credibility is through member checking (Hoffart, 1991). Member checking, or the feeding back of data/interpretations to research participants, was implemented informally. Sandelowski (1993) believes that member checking occurs "every time they [researchers] seek clarification for or elaboration of meaning and intention from the people they interview, or observe, or check out their evolving interpretations of the data they collect" (p. 4). Examples of member checking

are exploring the meaning of a concept such as "well-being" further with research participants, and seeking feedback on initial themes derived from the data.

Rapport was demonstrated through researcher engagement in the lives of the research participants to the extent possible given the constraints of the research situation. Each research participant knew me to some degree through activities with which I was involved at the Centre. Within an interpersonal context, rapport is linked with the element of trust in a relationship. Trust can be reflected in the degree of personal sharing that the research participants entered into within the research interviews. Within an anthropological frame, "most ethnographers hold a general axiom that the longer and better one gets to know the folks, the richer and more complex will be the understanding that results" (Agar, 1986, p. 57). My involvement with the Centre spanned almost ten months and contact with research participants occurred frequently. One other comment that warrants mention here is that because one of the roles that I have is that of a nurse, this may have fostered deeper and more expedient rapport with research participants, as a socially-sanctioned component of nursing is seen to be a caring persona.

Coherence is achieved through grounding the research analysis and conclusions in the raw data. An example is maintaining coherence through using the words of the research participants as much as possible to capture patterns of meaning emerging from the data. This example correlates with what Sandelowski (1986) describes as the criteria of fittingness; that the findings are grounded in the data. In addition, the stories and sentiments that the research participants communicate are integrally blended into the research by presenting their voices, sometimes in the entirety of specific speech events. Eisner (cited in Gale, 1993) defines coherence as research that "rings true." In order for the research to "ring true", certain strategies can be employed that provide structural collaboration. These strategies include

prolonged engagement, thick description, and diaries. These three strategies have been integrated in this research study. In the latter instance of diaries, both a decision journal and a reflection journal were kept over the course of the research. Sandelowski (1986) includes auditability as one criteria for rigor, and in this research, is manifest in the decision journal.

Complexity of research participants' lives is also incorporated into research presentations. Through attending to multiple contexts, the complexity of reality from individual women's perspectives is conveyed. Hall & Stevens (1991) underline the issue of complexity by integrating macro-level structures with the individual: "women, like all persons, are purposeful beings situated in particular historical, sociocultural, political, economic, and embodied life circumstances" (p. 23). One of the benefits with this research was using an open interview format that allowed for the emergence of macro-level influences in the daily lives of the research participants.

Consensus is reflected in the emergence of recurrent themes in the women's discourse around health. However, individuality is not dismantled by automatically decontextualizing women's experiences in search of consensus. Consensus can occur at different levels of meaning-making; that is, at one level there may be apparent consensus on meaning, and at another level (depth of exploration), individuality may be very obvious (Hall & Stevens, 1991).

Relevance addresses the issue of whose interests are being supported as well as potential research utility. In this study, the global intent, as established at the outset, is the Native and non-Native communication gap that I have observed repeatedly. Thus, in some ways, this research could be a stepping stone for moving the nurse-client relationship to a different level, beyond the assumptions and preconceptions that can drive and direct cross-cultural communication. In some ways, the research question is personally motivated. Yet in

acknowledging personal motivation, I believe that fosters my personal commitment to the individuals involved in the research process as the exploration is not only a means for me to expand my understanding of other's conceptions and context, but also may foster similar understanding in others. One key point here is that the relevance of this research exploring health meaning rests on an assumption that health conceptions in some (complex) way, mediate health behavior.

It is my contention that I have consistently integrated the characteristics of honesty and mutuality throughout the research process by freely sharing my views on the research with participants, and seeking feedback from participants so that this process stays grounded with the women. As set out at the beginning of this chapter, one of the guiding principles that I have used is working at establishing and maintaining mutual respect, trust, and an egalitarian relationship with research participants. Hall and Stevens (1991) succinctly capture mutuality by stating that "participants are assumed to be truthtellers rather than persons disposed to deceit or intrigue, peers rather than objects of study" (p. 25).

The last category for rigor is that of naming. In this study, naming power has been shared with research participants so that their terms and wordings are used to describe certain phenomena. As well, I have liberally integrated narratives and exemplars from individual women's stories as methods of illustration.

The above represents my reflections on reliability and validity within the process of research that I undertook. One of the many challenges in outlining and defending rigor is that this research is based in a naturalistic paradigm, and as the focus in on a human dimension, the progression of time and the inherent complexity of relationships makes true reliability (in terms of replication) difficult, if not impossible (Robertson & Boyle, 1984). Other critiques of research rigor operationalized in this research may be assessed through the reading of the

subsequent pages. This latter perspective of giving some responsibility to the reader is in keeping with some social science perspectives that believe establishing the trustworthiness of research is partly the job of those consuming the research. Putting this perspective forward is not an abdication of responsibility for rigorous research, but rather incorporates the view that reality is not necessarily singular, stable, or predictable.

> In the absence of certainty [e.g., one objective reality], knowledge is an ethical matter, one in which the judgement of each stakeholder must count. Once researchers are relieved of the impossible job of establishing the credibility or trustworthiness of their findings, the goals and assumptions of the qualitative research enterprise might change considerably (Atkinson & Heath, 1991, p. 163).

I believe this is also the essence of what Sandelowski (1993) attempts to articulate in critiquing the "inflexibility" and "uncompromising harshness" in applying criteria of rigor to qualitative inquiry. Mishler (1990) also writes of the social construction of knowledge and proposes that validation of research is demonstrated through giving "sufficient information to make a judgment of their trustworthiness and [we] can then decide whether or not to depend on them for future work" (p. 438).

Ethical Considerations

Hardin (1991) writes that a "human science paradigm ensures that the human realm will be treated with respect" (p. 94). A respect for persons was an integral part of this research. In addition, informed consent was sought, confidentiality was maintained, and ethical clearance was granted through formal review channels. Each of these areas are reviewed.

Ethical Clearance

The research, in proposal form, was submitted to the Faculty of Nursing at the University of Alberta for ethical review. Ethical approval was granted in early November (1994) prior to the commencement of interviews. As the community agency where I was

volunteering did not have an ethical review process, the review by the Faculty of Nursing serves as the single, formal mechanism for ensuring ethical appropriateness.

Informed Consent

Informed consent is an integral part of conducting research. Being informed means that those participating in the research know the potential risks and benefits and they are able to make a competent, independent decision regarding their involvement (Field & Morse, 1985). With this research, there was little chance of perceived coercion for participation consent as the researcher is relatively unknown to potential participants and there is little risk of harm (e.g., talking about health). Initial information that I shared with potential participants included the following: purpose of the research, time commitment, and background information on myself. If the woman verbally consented to participate in the research, then an arrangement was made for an initial interview. The issue of requiring informed consent was outlined in the preliminary information that I shared with potential research participants. Obtaining informed consent in a written format (see Appendix B) occurred at the beginning of the first interview. Each participant was given the option of either a written or verbal consent; all participants elected to sign written consents. Consent for other brief interactions with people at the Centre was not sought; I assumed some level of implied consent with the support of the agency for the research project.

There was a potential that revelations about personal information may occur during the course of interviewing that are sensitive in nature. As I was not acting primarily in the role of a nurse, but rather primarily as a researcher, I postulated that additional support for the research participants may be necessary. I sought out information regarding services available at the agency so that I could share this information with research participants if the situation warranted. In addition, I was prepared that if information surfaced that implied professional

misconduct on the part of health care professional(s), that I would direct the research participant to follow the formal channels if she wished to pursue a complaint (e.g., professional governing bodies).

Situations did arise in which I provided information to research participants about health-related resources in the community. I felt that I had both a moral and an ethical obligation to do this, especially in cases where personal safety could have been an issue. An example of the latter situation was ensuring that one research participant knew about women's shelters for abused women, and how to access this resource. In situations where I was sharing information, I perceived that I was acting primarily in an advocacy role, in keeping with a philosophy of mutual respect and trust. The respectful and moral decision was to intervene at a surface level to share information with research participants.

Confidentiality

Confidentiality of research participants has been maintained throughout the course of the research. Each participant has been given a pseudonym; names used in interviewing (and thus recorded on audio-tape) have been changed to the code name in the process of transcription. Other people's names were also given pseudonyms, such as the names of family members. There is a potential that a research participant may be able to identify herself in the data, or written product, therefore true anonymity cannot be guaranteed. Only I, as the researcher, had access to raw data; other members involved with the conduct of the research (e.g., thesis committee members) have access only to data that has been transcribed. All audio-tapes, transcripts, and notes are kept in a locked file. Consent forms and a code list of names are kept in a second locked file, separate from audio-tapes and transcripts. The audio-tapes will be destroyed seven years after the study is completed. Consent forms will be destroyed five years after completion of the study. The typed interviews and notes will remain

in a locked file. This information may be used for publication or educational purposes, and may be used for another study in the future if appropriate ethical review is sought. The preceding information was reviewed with each research participant during the process of seeking informed consent.

Research participants were told that there were few perceived risks in participating in the research, nor are there any immediate, tangible benefits. In order to be proactive, and act in an advocacy capacity, if sensitive information were to arise as a result of interviewing, and I deemed it necessary, referral would have been made to existing resources either at the agency or in the community. These type of situations did not arise in the course of data collecting.

Summary

In this chapter, I have established the grounding of the research by providing overviews of theory and methods utilized in the undertaken research. I have discussed such areas as studying across difference, knowledge and knowing, and concepts of culture and emic-etic. Reasons for employing ethnographic strategies within a qualitative approach were reviewed. Data collection procedures were outlined, and a brief discussion of analysis was provided. In addition, issues of rigor and ethics were presented. In the next chapter, gaining entry is discussed in depth.

CHAPTER 2: Entry and Access

Gaining Entry

Gaining entry is a complex and often time consuming endeavour, and for me, somewhat of a frustrating beginning to the research process. Part of this frustration arose from my own position of not wanting to impose on the setting and its people, and part could be attributed to entering a cultural world different from my own.

A desire to work with the Native community, but having no prior contacts prompted me to contact a Native community agency (referred to as the Centre) that I knew provided health-related programs. Initially I sought consent to enter the agency through one program stream and ended up becoming involved with another facet of program offering. After initial permission of entry (letter of support) was granted, I set out to "gain entry" into the agency, and access to potential research participants. I greatly underestimated the time commitment, persistence, and difficulty of this step of the research process. One factor in this difficulty may have been that I had no informal contacts with the agency who could have provided valuable information, even about organizational structure (Field & Morse, 1985). From my perspective, it seemed that each new contact was a new gatekeeper[5], and I moved through several gatekeepers until I found one that was interested in the proposed research and willing to accommodate my requests for volunteer activities. This experience reinforced for me that the granting of entry at the organizational level does not automatically translate into gaining entry into the "field" (Field & Morse, 1985; Ostrander, 1993). Another point of learning that occurred from the gatekeeper experience is that multiple points of entry should be sought at the beginning of the research (Wing, 1989). From September to December, I sought out volunteer activities and tasks in order to get known at the agency, and develop some level of comfort with people at the Centre. This time at the agency may be correlated with the phases

of getting in that Kauffman (1994) labels as behaving and swapping. Behaving is building trust and learning the language so that the researcher and those in the research setting begin to see the other as "fellow human beings" (Kauffman, 1994, p. 181). Swapping extends the relationships formed in the behaving phase to reciprocal sharing, promises, commitments, and mutual obligations. In the successive sections, an overview of volunteer activities is provided and reflexive comments are integrated in attempts to provide an understanding of the complexity of this research phase from the perspective of the novice researcher.

Description of the Agency

The Centre is a large organization serving the needs of an urban Native community in Northern British Columbia. Need, in this context, refers to promotion, advancement, and accommodation of Native people in cultural, social, educational, and economic areas. Using understanding of need to structure programming, four facets of programs are offered through the Centre: a) educational programs, b) health programs, c) social service programs, and d) economic development and employment.

My initial contact was the director of health programs (see Appendix C). I focussed my initial contact here as I believed that this area might be the most fruitful, based on my nursing background, for participating in volunteer activities. After repeated attempts, I was able to meet with the director and we discussed the outline of the proposed research. The first contact meeting led to a letter of support for the research. We met on a second occasion to discuss possible volunteer activities. After several failed attempts to meet with the health-related staff and jointly explore volunteer options, I inquired about other possible avenues of involvement. In response to this request, the director referred me to one of the managers of educational programs. Subsequent discussions with management personnel involved with education offerings at the Centre lead to my decision to concentrate my efforts for

volunteering and accessing potential research participants with this division of the Centr My decision was based on two factors: a) there is an opportunity for long term contact with individuals due to the type of programming being offered, and b) volunteer activities could be negotiated through the managers. I refer to this division of the Centre as the Learning Centre (LC). Programs offered through the LC are community based programs and the methodologies used are appropriate and supportive of participant success at the entry and re-entry level of adult education (Wishart, 1993). A qualitative case study of two programs offered through the LC identified six categories that characterized community-based education: comfortable and supportive environment, trust and bonding among participants and facilitators, sense of empowerment and confidence in participants, participant-focussed environment, community involvement, and staff and program flexibility (Wishart, 1993).

For the staff at the Learning Centre, the foundation of community based education is based on the following principles: empowerment; holistic (integrated) learning that addresses the physical, emotional, spiritual, and mental selves of learners; relevance; and healing. The traditional life skills model[6] for personal development is viewed as inconsistent with community based philosophies of respect, relevance, and personal choice (LC, 1994). Taking the perspective of community-based education within a learning environment leads to validation of learners and staff, and allows for collaboration, open communication, fostering positive personal relationships, as well as developing individuals' sense of self. In this latter regard, healing as a core philosophy integrates the psyche with the intellectual, giving validation to the whole self of learners and staff. Healing as a concept is defined by participants (learners) and facilitators (staff) as the following (LC, 1994):

1. Healing is facing and overcoming obstacles by being honest with our inner selves and by having positive thoughts and communicating openly. Taking each day one step at a time.

2. Healing is a process. With free will and honesty a person comprehends and understands the sources of the past and current traumas, pains and fears, and then conquers these negative experiences by cleansing the mind, the body, and the spirit.

3. Healing is anything that moves us toward spiritual, physical, emotional, and mental health.

Through reflection regarding my initial contacts at the LC, the sense of "people orientation" struck me as something unique and fundamental to the operation and success of programs. The LC has an informal atmosphere with art, pictures, and inspirational messages readily visible to participants, facilitators, and visitors. Hierarchy is non-apparent in that people are all on a first name basis, recreational/cultural/social outings are routine activities, and the primary focus is on the participants. Yet the needs of facilitators are not ignored; personal issues, crisis, and interventions are often approached from a team perspective. For example, one woman who was going to court (custody issue) was accompanied by another employee who acted in the role of advocate. Putting this situation in another context and philosophical paradigm would describe this situation as a secretary being accompanied to court by her boss. The perception of the woman involved was that her male colleague was accompanying her in support and advocacy roles.

Relationships and Establishing Credibility

After meeting with one of the program managers and describing my proposed research and general philosophy of the research plan, she referred me on to the director of education. On reflection, the meeting with this director was interview-like. In many ways, the meeting could be seen as the "impressing" phase of getting in. With impressing, both parties confront and judge the fittingness of certain stereotypes, myths, or typical characteristics that may match with given social status or categories (Kauffman, 1994). The potential for rejecting the one attempting to get in (the outsider) may lead to the outsider consciously working at impressing, and may indeed force personal reflection of values, perceptions, and stereotypes

(Kauffman, 1994). I shared with the educational director my beliefs about research being a joint venture, that I was taking the perspective of learner, that reciprocity is important to me, and that I wanted to establish connections with people before moving into interviewing. I think some of this sharing was motivated by my frame of reference of non-exploitation and partnerships emerging in reaction to the historical background of Native/non-Native relations[7] as well as the potential perception that the Native population is over-studied[8]. Sharing the above perspective was rewarded by the educational director through validating my beliefs regarding research, and the process of research. The philosophical congruence regarding research approaches was perhaps the critical point in the impressing phase that granted me entry into the LC.

At the conclusion of the meeting, I was asked to participate, as a nurse, in a week long healing event being held at a ranch in the central Cariboo region (subsequently referred to as the Healing Week). This was the first tangible activity with which I would be involved at the LC. Initially I had some reservations about being involved, primarily due to my own fear that I would be imposing my perspective on people through how I would define my role as a nurse for the participants at the Healing Week. After additional reflection and discussion with several facilitators, I decided that this role, encompassing certain activities and functions, would evolve over the course of the event. For me, this was an exercise in giving up control and allowing the needs of others to define my role rather than me defining how I could meet people's needs. A degree of uncertainty is reflected in my fieldnotes.

> Entry: The next morning we leave for the healing week. I still do not have a clear idea of what healing means, except that I expect the emotional pain to come out from the trauma and abuse that has occurred.

I saw the Healing Week as a valuable opportunity for me to gain insight and knowledge into Native culture, and also network with potential research participants. Yet I worried that I

didn't have anything to offer in terms of contributing to activities that were scheduled for the week.

Trying to keep my own expectations at a minimum was advantageous as this allowed me to become involved as a participant in the Healing Week, and my role as nurse actually engaged a minimum of time and energy. Activities at the Healing Week included talking circles, sweats, communal eating, recreational outings, breathwork as a form of release work, drumming, dancing, and several workshops. I found the sense of community that developed was the most rewarding aspect of the week. Some individuals visibly relaxed, others engaged more in conversation. Elders were a central grounding of the week. They spoke freely and openly, often praying over individuals when they were asked, they talked about the past, their past, and what they see for the future.

From my perspective as a researcher, this was an excellent opportunity for me to establish credibility with the Learning Centre community as people were involved at the Healing Week first and foremost, as people. There was a concentrated effort on behalf of the co-organizers to "equalize the playing field," so to speak, in order that participants and facilitators were equally involved with healing activities. Having this expectation explained at the outset of the Healing Week allowed me to be viewed as another participant, who also happened to be a nurse. However, in this environment, my primary identity was not that of a professional, but rather as a person participating in the event.

Being involved in physical activities, shared living situations, and communal eating granted me the opportunity to establish personal contacts with several women that I felt would be valuable research participants. This was a time of establishing trust and comfort, a time to begin relationships that would provide the foundation for moving into interviewing situations.

After the Healing Week, I was approached to do an evaluation of the event. The structure of the evaluation had been established by the two co-organizers of the event and eventually involved over thirty interviews (see Appendix D). Conducting the evaluation convinced me that I was addressing the wrong question in that I felt that if I was using an emic approach and forming the research question from primarily a community perspective, that I should be exploring the meaning of healing. However, I addressed this contradiction in research approach (that I was interested in healing by making a commitment in the research interviews to raise the concept of healing. This insight about my research question clarified how important and salient one's own perspectives become in situations, especially in research situations, where the researcher is formulating the question(s). Sometimes the question is an appropriate one from other's perspectives, other times it may not be and instead reflects an egocentric view of what the researchable issues may be with a given population or group.

With completion the Healing Week evaluation, I sought out additional volunteer roles through contacts that I had established with facilitators. One opportunity that arose was tutoring a participant in math. The participant was a man that I had shared living accommodation with at the healing event, and so we had some beginning relationship already established. Over time, the participant began to "accept" my presence, I am not convinced that he indeed trusted me or even liked me. Other activities involved more of a reciprocity with the agency. I was involved with developing a funding proposal based on the concept of healing, organizational activities for a second healing event that occurred at the Centre, and collecting resource material for several facilitators.

Getting In

Looking back over the months that I have been involved at the LC, it seems that it is a short period of time, yet almost ten months have elapsed since I first met the educational director. This has been a personal journey for me. I was committed to getting involved no matter how long it took. In many ways, the involvement that I speak of reflects my position of researching "with" instead of "on" (O'Neill & Waldram, 1989) and also is the avenue to getting in. Getting in is the process of building and maintaining trust that is critical to producing trustworthy research (Kauffman, 1994). Cook and deMange (1995) reinforce trust as being the "single most important theme in gaining entry to the Native American population" (p. 9). Initially I was frustrated with trying to get in, as I sought involvement, yet needed a route to do this. Many times I refocussed to the belief that I had to go with the agency agenda and their time; that I didn't want to impose my agenda on them and in effect, make my agenda their agenda (in relation to research time lines primarily). A second belief to which I was firmly committed was getting to know some of the participants and facilitators before asking them to be involved in my research project. Part of this comes from an uncomfortable-ness of being an outsider and asking for peoples' time, and another part comes from the perspective that connecting with people at some social level first emancipates the researcher-researched relationship to one based more on egalitarian principles and viewing research participants as people with inherent subjectivity, not "objects" of study. I have questioned how much of my commitment to pursuing social contacts first came from me not wanting to impose myself on the busy lives of women who are often already stretched to the maximum in terms of time. The conclusion I have reached is that I wanted to become involved and establish contacts with some LC participants as a way of both easing my own discomfort with imposition, and also working at shifting the power imbalances that can arise, thereby

increasing rapport and flow of communication for the women who chose to become involved in the research.

Summary

This chapter has discussed my process and reflections about gaining entry into a Native community agency. A description of the agency was provided, relationships were reviewed, and issues of establishing credibility and "getting in" were discussed. Gaining entry for me was a lengthy and time intensive process where I had to learn patience, as well as perseverance. Committing to this stage has been essential for establishing trust so critical in the research process, and perhaps even more critical when studying across difference. In the next chapter, the research participants are introduced through description and narrative of daily life and multiple contexts.

CHAPTER 3: Meaning-Making

Meaning-Making Processes

In this thesis, five women tell their stories about health and life to the reader through multiple presentations. I present phases of analysis that move through spirals of meaning-making and reflect different levels of interpretation. Condensed raw interviews can be found in Appendix E. The intent of including sections of the original interviews is to provide the reader with an overview of who these women are, and display the stories of their everyday life as told to me, the researcher, in interviews with them. From the raw interviews, the reader can follow through the phases of analysis; thus the process of meaning-making is made more explicit. The next presentation of the research participants is pulling through major content areas of interviews. These content areas are groupings that are central foci of discourse for the women participants. In this phase, beginning interpretations of research interviews are developed through short life vignettes based on contexts apparent in interview discourse. From my perspective, the discourse reflected four groupings for initial interpretation. These are: personal context, social and cultural contexts, health meaning, and health problems. In depth presentation of these multiple contexts represent the body of this chapter. The next method of presentation is the patterns of meaning that emerge across the women's narratives when one dwells in the data. These patterns of meanings either hold several meaning threads, or they are more holistic patterns of meaning. This presentation is found in Chapter 4. Moving on from multiple contexts, and patterns of meaning, research participants voices are next presented in their descriptions, and my interpretations, of health as "how you live your life." This presentation is found in Chapter 5. The final chapter (Chapter 6) draws the multiple presentations together through description and interpretation of what health means for the women involved in the research process. The central meanings and how these meanings

can fit into a model of thinking about health are outlined. As well, discussions on how these findings fit with existing research as well as brief implications of the research findings are included.

What occurs in the subsequent pages and chapters demonstrates the workings of what some may view as the movement from emic to etic, or what I view more as integrating and interpreting to reflect multivocalism. Interpretation and manipulation are parts of the research process in my attempts to come to an understanding of health from the perspective of the research participants. Some people would no doubt argue that I do violence to the data, yet I as the researcher am in a process of deconstructing and then reconstructing the phenomenon of health as a means of developing insight and understanding. In the acts of deconstructing and reconstructing, there is a transformation. Some of this transformation occurs at the level of the data, yet from my perspective, a major area for transformation has been at the personal level. This journey of coming to understand has in effect enlarged "my box"[9] about health, about society, culture, women, and about Native women within an urban environment. What type of insight is specific to each area is impossible to tell. It is about the journey of discovery, about myself, and about other people. So by making explicit the process of research and analysis, the conclusions of this research can be interpreted, critiqued, and debated by others.

To reiterate, the goal of this research is the exploration of the meaning of health for urban Native women. The use of ethnographic strategies allowed me to enter the lived world of the women that I interviewed (to some extent), and gain understanding of the influence of culture on certain phenomena like health. Because this research is exploratory, there are few definitives, rather the picture that I paint of health is formed through the brush strokes and paint that the women participants have provided. That is, the analysis represents a beginning understanding of the meaning of health as told by a small group of women who all, in some

manner, are linked with a Native community agency. Yet in making the statement that health is explored from the perspective of the research participants, there is inherent contradiction because I as the researcher am attempting to make sense of their stories, discourse, and narratives in order to reflect coherent meanings. Using participants words and narratives provides the structure for a beginning description of health meaning.

Before proceeding with data presentation, several comments are warranted about how I present the data. I have taken liberty to edit the original transcripts of interviews (Appendix E) to give the reader perspective and flavor in relation to the type of information shared, and the relationship between myself and the women who were involved with this research. Editing entails subjective decisions on my part regarding what data to include and what data to exclude. I used a guide of presenting a variety of information that tells the story of each woman, yet I tried to localize the data to the health domain and the dynamics of health data. The text that is italicized throughout the remaining pages is either indicative of my speech, thoughts, or making connections to facilitate understanding of presented information. In some situations, language has been simplified for ease of reading and understanding, although I attempt to retain the flavor and style of the original speech events. In other situations, I have taken the "narrative licence to arrange words or sentences together that were not necessarily spoken together or in the same sequence as in the original transcribed text" (Sandelowski, 1994, p. 481). As with simplifying the language used by participants, I try and ensure that the research participant's meaning has not been altered or misinterpreted.

Meaning-making Through Contexts

This phase of data presentation is an exploration of the contexts of women involved with the research project. For some women, certain contexts are more salient than others. Salience mirrors the temporal nature of every day life. That is, based on time and context,

certain aspects of self may override others in the ongoing navigation of life. For each woman, I have developed her own story following a condensed life vignette format (Warren, 1986) that allows the reader glances in to the realities of each woman's life. Through telling individual stories, meanings in relation to personhood and health can be exemplified for the women I interviewed. After the vignette presentation, I move into the world of the researcher, and reflect back on the interactions with individual women in attempts to explain further my role in the research process, as well as how meanings co-evolve. I have many reasons for developing this section, but most important is trying to maintain truth in my perspective of valuing individuals and not objectifying the women that I interviewed, as well as paying tribute to the women who gave their time, and shared story-telling as a way to help me understand. I begin with Margaret's stories and my interpretations of both the interviewing process and our relationship.

Margaret

> I think maybe that is why I'm having all these problems because I want more for myself and I don't have time for that because of my kids. You know? But I am managing to do both, going to school; this is something that I really want for myself.

Margaret has lived in the city for about a year, raising five children on her own, and attending school full time. Little time is left over for "herself" as she juggles the multiple responsibilities of a single parent trying to move ahead with her own personal goals for her personal development. She has been divorced about six years after leaving an alcoholic, abusive husband.

Personal Context

Margaret describes herself as earnest, adaptable, fair, and an optimist at heart. She believes that she wouldn't be where she is today if it were not for the fact that over time she

has learned to adapt and change, both in ideas about things and people.

> I think that is the way my life has been, changing all the time. You know, when I think back I have been changing myself. Like learning new things, being open to new things, to change. And that's where I find that it works good for me. If I wasn't adaptable, if I wasn't open, I wouldn't be here.

This characteristic of adaptability fits with the prevalent theme of learning that is emersed in the dialogue about herself. An example of a learning theme is when Margaret recognizes that she has inadequate resources to feed her family in a healthy way, she seeks out people to help her learn to meet this need (in her role as provider). Some of that learning came through experience, other learning she gleaned from nurses, social workers, and counsellors.

> Probably through my own experience, lacking vitamins, I started getting sick and tired. Because I wasn't feeding myself as well as I should have been. I was worried about feeding the kids, what they were getting, and I started getting sick, from not getting enough nutrition, so I kind of learned from that.

And learning to do things differently reflects the ability to adapt, as Margaret recounts in her experiences after going out on her own.

> I used to have to put money aside and forget about it until we started running out, then I would take it out and use it. I learned the hard way. It was hard. *Is it still hard?* Not so much anymore. I have learned alot of ways to watch my money, to budget, you know, get the most of things.

For Margaret, her personal identity and self-definitions are intricately linked to her roles, responsibilities, and meanings as a parent. Her feelings reflect a struggle to gain some sense of self that is separate from her self as parent, yet at the same time, she values her role as parent.

> The way I think, the things that I do, like even when I'm here [at school] I know that I want to complete so many assignments because I have kids at home and I only have so much time, I can't do that. I have to work right around the kids, you know, the things I do for myself are very little. I plan to make more time for myself, the things that I want to do, but then I get this guilt setting in. You know, it's hard to get rid of that. I have too many responsibilities as a mother to my kids and I can't, I have a hard time with making out the difference, where my needs are not as important as theirs.

Conflicting emotions about parenting and her ability to parent are prevalent in Margaret's telling of her everyday experiences. An historical dimension is apparent in some of the comments that she makes, in that she believes part of the trouble she has with her two eldest daughters is due to the fact that they don't respect her much. She notes that this does improve over time. Yet Margaret feels that this disrespect comes from two sources, one being the fact that they saw her being abused both mentally and physically by their father, and secondly because the two girls lived with their father for periods of time after Margaret and he split up. Margaret perceives that this is an opportunity for the father to degrade her even further, and how much of this the two eldest daughters have internalized and believe, Margaret is not sure.

> It's easier with the younger ones, they have more respect. I was trying to build up my self-esteem at the same time that I was trying to help Jan with hers. It gets better with time, you know what I mean? That each kid seems to be a little better that way. Like Jill has better self-esteem than Jan did at her age. And I'm really working with the younger kids on that.

Minimal resources also influence her attitudes and interactions with her children. Margaret does a double shift, being in school all day and then coming home to her responsibilities as a parent. Margaret has ongoing frustration with "having to do it all" and having little or no help from her two eldest daughters.

> See like yesterday, I was looking around the house, there is so much to do here. The kids were gone and I'm looking at this mess and I have to clean it, and then make supper and then dishes. And I was thinking "Why am I the only one that has to do this?" You know, it's starting to really bother me.

In addition, Margaret feels somewhat isolated in terms of available support, both personally and as a parent. After being in the city for a little over a year, she is just now beginning to develop a few friendships and is reluctant to burden them with her problems, feeling that "everyone has their own problems, I don't want to add mine to theirs." Compounding the isolation and lack of support is a tangible lack of financial resources. And given this reality,

Margaret constantly manages, even saving enough money to buy a car on payments, and insure the vehicle in the near future. Financial constraints affect the dynamics of parenting, and her own self-esteem.

> Lately I've been home alot and I think that's what has gotten me. Because I'm the kind of person that is going and doing, doing all the time, whether it's going to visit someone or take the kids to the park, you know, going somewhere, doing something. I don't have a vehicle and it's hard for me financially. I think that has gotten me down alot, that's bothered me alot. *Like staying at home, not having a car, is that self-esteem or is that, uhm, mental state or what?* Ya, it ties in with self-esteem, I can see it with that because I'm not fulfilled. Because I have left so much out, and being at home, the way I describe it is being "stuck at home".

Another variable that influences Margaret's parenting and relationships with her children, is the influence of alcohol in both her life and the lives of her children. She shares with her children her own experiences, trying to prevent them from the pain that she endured in her married life.

> My daughter and her boyfriend both drink, I don't know how often anymore, but Jan is really trying to stay away from it and he's not helping much. But I told her, I keep telling her, that she's making the choice. "You don't have to drink, if he wants to drink, let him get drunk and have the hang over and the guilt about what he does when he is drunk, what happens".
>
> I never touched a drop in the last three years of our marriage, I wouldn't drink anything at all. But he kept it up and kept it up. And I felt like, he wasn't in a proper state of mind to deal with things, I couldn't talk to him. I didn't know if it was the alcohol talking or if he was being honest, or. Alot of hurt came out of that because I was sober.

Social and Cultural Context

For the first five years of her schooling, Margaret was the only Native person in her class. She recalls that she had a hard time, being called names. "I knew that I was Native, but I didn't realize how much criticism I would get from that, how much harassment." Margaret's way of dealing with the racism and prejudice (overt and covert) she encountered

was to work at fitting in, being like the other kids at school. She worked hard to excel academically and be like everyone else.

> I wanted to be good as the strong kids, and I could be as good as them, smart as them, I did really good, you know. And after a while I found out it didn't matter. My skin colour didn't change. My hair colour, my eyes, none of it changed because I was just as smart as them. They still had the same attitude about me.

Margaret recalls sexist remarks in high school, of being the school bully in reaction to prevalent attitudes about Native people. After getting out of school, she realized that she didn't have to be tough for anybody anymore, and that she could be herself at home, with her partner and children.

During her teenage years Margaret tried to gain as much information as she could about Native culture so that "I could be on either side, either white or Indian." Yet she was constrained by the fact that she lived in the city, and by the fact that her parents were not involved with much in terms of cultural practices.

> I guess I was going back and forth between being Indian and being White and which way I was. I've been called an "apple", red on the outside and White on the inside and that's actually, that really put a damper on me when I was trying to learn about my culture, about being Native, being Indian. So that really dampened everything for a long time. I went on doing whatever I had to do and trying not to think about it too much.

Changing times, changing attitudes, and additional learning within a Native agency have fostered a sense of pride in being Native that Margaret didn't have before. During her growing up years she faced societal attitudes that "Indians drink alot, that they don't know how to look after their kids, and that they are unclean." She perceives that attitudes have changed due to additional opportunities for and achievements by Native people. Margaret shares with her children what she learns in school about Native people and Native history, wanting to instill in them the same sense of pride that she now has in her heritage. Imbedded in this discourse are meanings of race and class, which she captures through the eyes of her children.

> I find that the children are not as aware of being Indian as they are of their class, you know, like middle-class, lower class. They are more aware of that, they are paying more attention to that than their own culture. Now they are starting to catch on, they realize that they have something to be proud of, they don't have to hide behind being Indian or what people expect, you know.

Health Meaning

For Margaret, health meaning begins with an ideal, that of breathing normally and being able to do normal things. She typifies normality as activities such as waiting for the bus, going for a walk, going to the store. This health meaning is embedded in her own context of health, in that she has ongoing respiratory issues. Another personal context that drives health meaning is the issue of being overweight. Margaret's weight also interacts in complex ways with her self-perceptions, and physical condition. In addition, her family is intricately linked to her own perceived health status, and she in turn affects the health of her children. The following passage reflects this dialectic.

> All I know is that I can't, like my kids are so much a part of me, my lifestyle and everything that goes on that, like it's obvious that what goes on with them is a part of my happiness, my health. And I have alot to do with the way they are, their health, health aspects and what not.

Margaret also readily describes activities for health. These include giving the children vitamins on a regular basis, having the kids play outside as much as possible, exercising, and eating the "right foods" (milk, fresh fruit, and vegetables).

Lately, Margaret sees herself as being "off balance" in relation to health as she's not able to do the things that she wants with her children, and also because she needs "something for myself." Balance for Margaret (in relation to home life) means "that we'd all have our own little things to do, our own time, and then we'd have our time together." Integrated into this dimension of time, is Margaret's desire for self-satisfaction.

> I'm just wondering if that's what keeps pushing me, keeps me pushing all the time, doing all these extra things. I always seem to push myself. And maybe

> that's what I'm looking for is that little time by myself, because I always feel like I'm looking for something, reaching, and I push myself to a point of self-satisfaction and I can't get there.

Health Problems

Health is also viewed and described through what it is not. The boundaries of health may be easier to describe through providing examples of health problems, or sickness.

> I had asthma and gestational diabetes, my blood pressure was up and down, everything went crazy with my last pregnancy. I have had quite a few health problems, all kinds. I have always had bad ear aches when I was younger, like growing up I had alot. And problems with my teeth, and my stomach. I had ulcers by the time I was seventeen. Now that I look back at it, I haven't done too well [laughter].

Health problems for Margaret also tie in with her personal context and her daily life. She wonders if the reason that she has been so sick with her asthma lately is the stress that she has been under due to troubled relationships with her children. And the fact that she is "changing gears all the time", going from home, to school, to home. Margaret tries to give meaning to her recent and frequent illness through causation, disclosing that she notices when she has a hard time with her children, like arguing or yelling, or feeling neglected by them, that her respiratory condition deteriorates.

> I am trying to watch that over the last couple of months to see if that has anything to do with it, you know, the stress. And it seems to me that it looks that way to me, that's a part of it. Besides the smog here [laughter].

Personal and social contexts are blended with health meanings. Margaret links stress, which she defines as worry, to her health in that when she is worrying, she doesn't look after herself properly so that her defenses are weakened, and she becomes more susceptible to colds, asthma attacks, and fatigue. Not looking after herself means staying up late, not eating right, and being out in the cold when she shouldn't be.

When talking about her present issues in terms of health, Margaret recounts ongoing

physical limitations and doctor's advice for surgical intervention. She sees surgery as a threat, a time when she is not in control, and a time when she must place her trust in another person. Having someone take care of her is a foreign experience, and not one that she will enter into easy. With this specific health issue, Margaret feels that she has ignored the physical signs of her body to the point where a decision has been made outside her sphere of control, that is, "I've been putting it off, and now it's gotten to the point where I could be in big trouble, you know?" She admits part of the problem at a personal level is that she tends to put things off, avoiding dealing with the problem until she is pushed to the point where she has to make a decision one way or another. Again, Margaret talks of balance, and trying to find a balance between worrying about her present health situation and seeking out enough information so that she is informed and comfortable with that information.

Interpretations and Reactions

With Margaret, I feel that I know much about her life. Our relationship began at the Healing Week, where we shared living accommodations. Communal living allowed us to establish a personal connection, as the intent of that event was personal healing (and through extension, community healing). I had the opportunity to share my interests in Native health with her, and she shared much about her life, both past and present. This grounding in terms of a personal relationship provided the building block for extending our relationship into the research situation.

Margaret was the first women that I asked to become involved in my research. I had some reluctance asking her to participate because I knew that her time was precious and that she had many responsibilities as a single parent. Yet I also believed that she had many stories to tell, and that perhaps in the telling to another, she might explore options and discover additional meanings for herself. I also got the sense that she just needed someone to talk to.

And to a large extent, our interviews reflect that tone; of friends sitting down to catch up with each other. In addition, I believe that the fact that I am a nurse provided Margaret with the opportunity to explore her health issues by pulling in the influence of daily life stresses.

Having some insight into past health problems and her personal life from our time at the Healing Week allowed me to integrate this information through questioning early in the interview process. Even with having our relationship started, questions about meaning of health led to somewhat closed responses. I truly wanted to get at some of the dynamics around health, but at the same time, I realized that I must temper this enthusiasm so that I did not force connections that were not there from Margaret's perspective. Inadvertently, finances emerged in Margaret's discourse in terms of how limited finances influence health status. In addition to finances, family and relationships also emerged in the discourse about health.

At times, I viewed our conversations more as a form of therapy for Margaret, as our time was an opportunity for her to talk about every day life situations. My questions usually began by asking her to tell me what had been going on with her lately. This type of questioning granted her permission to take the interview in any direction that she wanted, or needed at that time. She often began by talking about her children, and about mother-children relationships. Moving on from this content was sometimes difficult, and I used prompts in attempts to connect Margaret's personal context with health, and understanding of health. The following passage of interview demonstrates the interaction of researcher and participant.

> I have found myself over the last few weeks hollering and hollering and I hate doing that. I've even been dreaming about it. *Dreaming about yelling at your kids?* Ya, yelling at the kids, their reactions to my yelling. Dreaming about yelling at the baby and the younger ones. It just bothers me, I guess because to me it's not right, but then I run out of patience and I go, I get really mad really easy now. *Do you think that some of that ties in with the lack of support that we talked about before?* Ya, I really feel that I have barely any support systems other than here, and it's not really much here because I'm here to do my academics, other than that I don't really talk to other people about what's going on, other than this [interviews with me].

Somewhat in contradiction (or perhaps in complement) with the above discussion where I, at times, try and help Margaret see connections and develop insight into her reality, is working at being a learner, of trying to understand her reality that differs from mine. At one point in our conversations, Margaret talks about the inability to separate herself from her mothering identity, and having to always work around the children.

> *How does that make you feel?* Uhm, important, needed. It's a good thing. It's hard, but it's a good thing for me. Being important to my kids, to their lives. So that's an important thing to me. *So that's where the rewards come from? Being a non-parent, you know* [laughter]. Ya, if I could tell you the rewards.

Putting myself in the role of learner is an act on my part where I work at equalizing our relationship. It is trying to gain an egalitarian relationship where Margaret does not place me in a role other than that of a confidante.

Allowing and granting permission to explore her relationships with her children through our discussions provides me with much opportunity to unravel the complexity of health meaning from Margaret's perspective. What struck me was that in discussing health initially, Margaret began with the concept of normalcy in relation to physical health - breathing, activity. And through successive discussions, this concept of health grew so that it became multi-dimensional and incorporated her realities of everyday living; of being a single parent in a city with few friends, of the salient role of stress in her life, and of living on a fixed income that is often insufficient to meet daily needs let alone emergencies such as visiting a sick father in another city.

Inherent in my questioning was some level of expectation in terms of Margaret's response. Often times her responses surprised me, perhaps due in part to my subconscious, preconceived ideas about Native people, and Native women in particular, and perhaps partly due to the socialization I have received through reading about women's issues.

> *I am thinking about how you would define yourself. Because motherhood is such a big part of who you are. Are there other parts? If we had never met before, how would you define yourself?* [at this point I expected Margaret to talk about her Native identity as a marker of difference, because I assumed that her heritage would greatly influence her self-definition]. It's hard for me to say. Earnest is one of the things. I tried to describe myself on paper at one time. Adaptable was one of the things. I find that I'm really good at that. I used to think that I was really quiet, but not so much anymore. *Where do you think that ability to be adaptable comes from?* [to this question I expected that Margaret would talk about her marriage and the fact that being in an abusive relationship requires that she be adaptable to her ex-husband's reactions so that she avoids physical or mental repercussions from her talk or actions.] Uhm, I don't know. I think that I have had to make so many changes in my life, like that I have had to think differently about changing attitudes and changing thoughts and ideas about things, people. Uhm, like for instance, going to school I was the only Native at school. And at first I didn't recognize that as a problem, and then I found out it was a problem. I think that's the way my life has been, changing all the time. If I wasn't adaptable, if I wasn't open, I wouldn't be here.

This concept of adaptability is something of a survival strategy. Being adaptable is a strategy for making her way in a world that is not always receptive to her as a person.

I looked forward to meeting with Margaret, even if it was just to say hello and have a brief conversation as a means of checking in. If Margaret saw me around the building, she would always stop and talk to me. At times, I moved out of my "researcher" role and talked with her about community resources that may be available to help her with parenting issues, and explored with her additional options for when her money was especially tight. There were other times that Margaret was able to use me as a resource, in seeking out information regarding the reason for her father's hospitalization, or explaining about the pre-operative process. These interchanges were rewarding for me, as I felt that information was being shared; that I had certain information that Margaret was seeking, and she had information that I was seeking. The reward was that there was some level of reciprocity.

Janice

> It makes it harder when my husband is home. When he's home we spend more time together and we're doing alot. But if my mom were to phone and say that she needs to be picked up, it's like, right away he's gone. But if they are constantly asking me, then I feel that they are taking away from my family, because I only have so many hours in a day that I can spend with my family, you know, my immediate family before the kids have to be in bed and stuff. If I'm out all the time, it seems, that I build up more stress or guilty feelings.

Janice is a young Cree woman who has been raised in an urban environment. She has had little contact with Native cultural practices until recently, and these recent experiences have been through her involvement at the LC both as a participant and now as a facilitator. Janice has two small children and a husband that works out of town for large portions of each year. For her, parenting has been primarily her responsibility. In addition, she has extended family responsibilities.

Personal Context

Janice relates stories of a life that is busy and eventful, and of relationships that are rewarding at times and frustrating at times. Employment takes up a large portion of Janice's time, and what other time is left over is full of activities with her children, husband, and extended family. Time is a constant factor in her life: not having the time to cook the type of meals that she wants to and instead taking the children out for fast food on the way home from the babysitter, having to be more than one place at the same time, trying to meet the needs of her mother in terms of driving her to visit family, and carry out routine daily activities. Motherhood consumes her daily life and lone parenting for a large portion of the time adds additional responsibilities.

> Being the mother, getting the kids ready, off to school, get their suppers and what not. Paying the bills, looking after the finances, making sure this is paid and that is paid to disciplining the kids. I don't know if my techniques are the greatest at times, I shake my head over some things. And all round decision-making.

Procrastination is something that Janice has fit into her life, and often wishes that she could change. She sees that by pushing things away, and putting things off, she is actually causing herself additional stresses that she could avoid if she stopped procrastinating. Engrained with procrastination is salience, that is, dealing with the most important or pressing concern/issue and the other concerns/issues are pushed away. Part of this has to do with the multiple roles that Janice enacts on a daily basis and part of it may be due to survival skills when an individual is over-loaded.

Self-perceptions and meanings are pervasive in Janice's discourse, and in relating several stories, it is apparent that situations that she has encountered over time have made lasting impressions on her, on how she feels about herself, and on how she feels about other people. Critical incidents have been integrated into both self-image and body-image.

> One thing about me is that I have always worried about how people feel about me, and I have made that a big part of me too. I have always wanted to please people. And I've always been leery about how they think I dress, mostly when I was younger. I am grown up now, and I can still see it come out in part, but it's not as bad as how it was when I was younger.

Another theme that is recurrent in conversations revolving around personal context is the issue of weight, and Janice's self-perception that she is overweight. Here she discusses the complexity of self-perceptions and links her personal context with social/cultural contexts.

> *That's something that you've brought up several times in terms of weight. I don't see you as being an overweight person.* Ya, I guess that, it's always been, like what I said before about having always to please other people, that has always been with me through high school. I am one person that if someone has made a remark about what I look like it sticks with me. And that's probably why it plays back to me.

Imaging is often dictated through prescribed social norms. With varied social norms, depending on the rules of inclusiveness and exclusiveness, one can encounter contradictory messages that are also internalized at a subconscious level. Gender imaging in relation to role socialization and how contradictions can be addressed is apparent in the following passage.

> I was raised in a family where my dad worked all the time, and my mom was home but she always did the motherly things. *She worked full time at home.* Oh basically ya, definitely. And so, I find it kind of hard now with my husband. I get by myself, irritated when he's home and looking after the kids and what not, but the house is upside-down. And I'm working full time, so I think that kind of adds, it all comes together. You know, like I will say "you've been home all day, what have you done?" Which I have heard said to me before, but that was in the first part when I started working, now I know I've really relaxed in that area. But I still kind of, I do actually still feel that inside. And he's asked me also to let him know what, and I did say, you know, "well, I think that if you had a steady job that things would happen more."

Self-definitions and perceptions relate to how Janice enacts her life, and how she makes daily decisions about life, family, and health.

> *How do you decide what's good and bad?* What's in your self. You get a feeling of whether you should. I do, I can't say you do. I get a feeling inside myself and I know that something that I am doing is wrong or whatever and I make the judgement on it. Nobody is going to know for each other what's good and bad for them, you know, you've got to know that yourself. *So what's good for me might not be good for you?* Right. I feel anyways. But everybody's different.

These concepts of good and bad fit with the concept of "rightness", of things seeming right. There is a prevalent perspective at the LC that if things are done in a "good way" that the intention is good and therefore no harm will come to those that implement a given action and those that are involved with the action (fieldnotes).

Janice talks about the influence of alcohol in her life, of growing up in an alcholic family and how that influenced her self-esteem. She thinks that her own low self-esteem has held her back from doing some of the things that she wanted/wants to do. Personal work has fostered self-growth, and with this process, new goals and directions have been planned. Yet there is an element of instability in Janice's life that she attributes to having an alcoholic husband. This in turn influences her parenting role, and taking on primary responsibility for her children even when her husband is in town, due to the fact that if her husband is drinking, she can't "depend on him."

Social and Cultural Contexts

When Janice first became involved with the LC, she struggled with the differences in beliefs between what she terms Native culture and Christianity. "For a while I was really confused inside and I wasn't sure. One lady that I respect and look up to expiained to me alot better of how I was feeling because she had been through the same thing." The same thing that Janice refers to is that some individuals at the church she was attending referred to Native culture as "devil worshipping." Now she feels good about her involvement and participation in cultural activities, be that sweats, or powwows. Personal curiosity has sparked her involvement in cultural activities.

> I was raised in the city and my family isn't really cultural at all. We didn't have any real cultural background, of our ancestry. Once I started coming to the LC and learning about culture, taking part in it more, it just seemed like that I wanted to know more. I wanted to, you know, this looks interesting, this doesn't look bad. Like Native people did this for years and we are getting back into it now.

Another aspect of being raised in the city is that Janice went to public schools that didn't have many Native people attending. She recalls being called an "apple Indian" - red on the outside and white on the inside. Her interpretation of this was that she was Native but didn't know any of her culture. First she took offense to that, and later decided it made sense, that attending public school she didn't learn anything about her culture, "nothing like what is available to students now-a-days." Over time Janice has begun to learn about Native culture, practices, traditions.

> I have always felt sort of lost in that area, there were people that we knew that were into the cultural things. I just thought of them as kind of different. They did Indian singing and drumming and stuff. And of their cultural things that they believe, that they practiced and what not. I always thought of them as like real Indians, you know? [laughter].

Trying to separate spirituality and culture is difficult for Janice, it is as though she views the two as so integrated that she cannot separate them. Learning about Native culture has swayed

her so that she no longer attends the church that she used to, instead favouring the cultural direction that in her view is much more encompassing of various religions and belief systems: "And with Native culture you could be Christian, you could be whoever and take part in the cultural activities." Some of Janice's background in terms of religious practices carry over into her life today, and that is something that she likes about Native culture, that one can adhere to some other beliefs, "you're not destined, they don't restrict you to what you can or cannot do."

Cultural contexts are blended with personal contexts in Janice's discussion of her own heritage, and the meanings she associates with being a Native person. Growing up in the city, Janice felt that Native people "weren't as good" but now this belief has changed. She recalls in detail an example from her early teens when she was called a "dumb Indian" in a very public place. I ask if she has "put that dumb Indian away?" to which she responds:

> I guess I looked at it, like now, ya. I mean I feel, then I wasn't, not knowing enough about my culture. I was a bit ashamed of being Native. I thought it was bad and that. But now, no.

Health Meaning

When asked what health means Janice replies that "it means eating right and getting exercise, you know, feeling good about yourself, and health can mean just your mental being, how you feel about yourself." Through the process of interviewing, Janice also brings in the dynamics of health, such as the connection between health and stress. She perceives stresses within her relationship with her spouse and day to day stresses in terms of what has to get done in a given day.

> I feel that stress affects health. I feel anyway, that your body gets run down, you worry and think about things so much that you forget about yourself and then it catches up with you, in the way of getting sick.

Over the course of interviews, Janice develops a picture of health that has four dimensions: physical, mental, emotional, and spiritual. Her picture of health is influenced by learning

about the concept of the circle and the medicine wheel through courses and employment at the LC. For Janice, spiritual is what her beliefs are, what she believes in, and she links these beliefs to a higher power. "If I believe in something that is doing me good and not doing harm to others, then I would say that would be healthy." Tied in with the belief about health as having four dimensions, is the concept of balance and the dynamics of balance.

> If you have one of those out of balance, you have something, not really a ruckus, but something. Actually I look at that alot in terms of that I know for myself that if I'm not doing something for myself, play or fun, I get really stressful and I get to the point where I am grouchy.
>
> I'd have to say that with the balance, like sure it is always happening on its own, the things that you do with the four components, but you have to make sure that you do, that you are getting them because it's so easy to work and family and you can throw yourself into that so much that you forget the rest. And you don't realize actually, what you're missing, what your body needs or whatever. So you have to do a check in order to keep the balance.

Health and unhealthy are explained in how Janice thinks about her mother, a woman with chronic illness, and a husband in a care home due to stroke and early Alzheimer's. When talking about her mother's health, Janice reduces her conceptualization to that of physical health, saying that although her mother adheres to her prescribed medication regime, her chronic illnesses sometimes get out of control and this leads to emergency treatment and often hospitalization. Hidden in Janice's discourse is a focus of management; that chronic health conditions and daily living interfere with health as her mother doesn't manage her situations/circumstances. The words that Janice uses are that "she [mother] isn't looking after herself." Expanding this view of her mother, Janice explains further:

> I think health is being able to do, activities and stuff. For my mom, looking at her now, uhm, she really can't do too much. I don't see her "in health" in the physical sense. Mentally, her illnesses has affected her in maybe ways that she feels about herself, how she thinks about herself.

In referring to health, there is an individuality of health meaning and operationalization. That is, for Janice, she may need to do certain things for her to be healthy, and yet for someone

else, those activities may be different. Personal knowing about "what has to be done for me" is critical to gaining and maintaining health; "no one can tell me 'you have to do that,' you know, I've got to know."

Initially Janice's conception of health is reflected in terms of "exercising, dieting type of words." But after discussion of some initial themes from interviews, Janice expands her meanings to encompass personal life, and what one does. Social and cultural contexts are also blended in with meanings of health, and this is something that Janice came to recognize through our discourse about life and health.

> *When you think of health as diet and exercise and all those things, where do you think that comes from?* Exactly. Ya, I know where it comes from, not exactly that I know where it comes from, but for me, I know alot of it is our society, it's on TV, it's in the papers, your appearance, you hear so much about being skinny. And alot of what I'm hearing now is be happy with who you are, if you're not happy with who you are, you'll never be happy.
> *And are you getting those messages from the same sources?* Uhm, well I've heard on TV, a talk show or whatever it might be, I've heard those things there. But of course it's nothing that's as widely publicized as being skinny and fit.

Health Problems

Janice has asthma, and believes that her asthma wouldn't bother her has much if she was exercising more. And she also believes that she would feel better generally if she exercised more. The complexity of her asthma, self-perceptions, and exercise are exemplified in the following:

> Before I had kids I worked out, and I actually played sports alot. And so I got to the point where, you know, my asthma wasn't really, it isn't a really big thing but I still feel that at the age I am, it's deteriorating a fair bit. Like, some bit, and so I feel that if I was able to do more for myself, exercise more that I would feel better. So that's why I think that I don't feel so good about myself. I have gained too much weight and it has affected me, in my more complicated self.

In managing her asthma on a daily basis, Janice implements a strategy of putting off. She knows that her asthma worsens with the Spring season, she needs refills of her medications,

yet that is something that she has not yet done. It seems for Janice, that refilling her medications receives a low priority even though at an intellectual level she knows that her medications help her breathing ability. Part of medication refilling getting a low priority may be explained in Janice's confession that she is "a bit leery about the medicine." She wonders what the medications are doing to her, questioning whether the medications will in fact make her worse, and then also believing that she's "not that bad" and therefore not needing to take the recommended amount of medications.

Interpretations and Reactions

I also met Janice at the Healing Week. We talked briefly at that time about my intended research. It wasn't until later in interviewing that I realized that she had offered little information about herself, instead, focussing the conversation on me. When I approached Janice to be part of the research, she took interest in the process, asking questions about me, and about how I was going to "do" [illegible]search. For me, that seemed important, and perhaps in reflection, this interest could have been [illegible]serving as a form of protection, but it also could have been that Janice act[illegible]s out new experiences and activities for intellectual challenge. I had an immediate comfort with Janice, and this may have been because she took an interest in the research topic and process.

Janice seems somewhat analytical in her approach to questions. She takes time to think before responding. Stories are willingly shared with me, and interviews have a conversational tone to them. Initially it seemed Janice had some frustration with her life the way that she is currently living it, almost a restlessness about her. Over time, Janice's trust in me developed so that I was able to ask about alcohol issues within her family. I knew that there was some stress in her relationship with her spouse, as Janice did address this vaguely at

one point. Yet I felt that there would be a right time for her to share additional information with me. Repeated contact allowed for this opportunity to present itself.

At different levels I could relate to Janice. I could relate to her experiences of mothering consuming most of her time away from work, as I have friends that talk about this reality of mothering. I could relate to her frustrations with her husband being at home and not "doing" much of anything, when she knows that certain activities make home life run smoothly. And I could relate to her issues of control, and wanting structure in her life. Sharing my stories intermixed with her story-telling demonstrated that we had (at least) some gendered and generational similarities.

Jody

> I could have had a job, I was offered a job but it wasn't what I wanted. I didn't want to stay in that low wage-type of thing where you just barely live from paycheque to paycheque. So I decided to make a sacrifice and do something about that. That was hard, giving up all the things that you have, that was hard.

Jody attends a program at the Learning Centre full-time, often showing up when several of her classmates have chosen not to. School is a way of keeping Jody's sanity, and in a way it is a break from daily responsibilities of mothering and being a wife in an unhappy marriage. Jody grew up on a reserve several hours drive from the city in which she now resides. Now the years living in cities outnumber the years spend living on-reserve.

Personal Context

Throughout the course of interviews, Jody struggles with making and implementing decisions in terms of her marriage. She is in an abusive relationship, and has tried many ways to deal with this. The latest blow came when she learned that her husband was "not being truthful about all the things that were happening" and he was dismissed from counselling. For

Jody, this seemed to be the final straw, and she made a decision that he must leave the household. Yet the challenge lies in actually getting him to leave; how to implement her plan of action. She talks of ongoing problems of promises being broken and of her husband not carrying through on his intentions.

> I was just telling my group [classmates] this morning that you can see the cycle, the honeymoon stage is over now and it's the tension stage. That's exactly how I feel, the tension. Sometimes I feel like I am the crazy one [laughter] and then I find out that I'm not alone, that it's not me. Like that's where he's always directing things at me, like I'm the one that is at fault, that's why he does these things.

In this passage, Jody verbally recognizes that she is not at fault, that she does not cause the abuse. Knowing that she is not alone may provide some additional strength for her to act on her decision that the relationship must be terminated. In the end, her husband did leave when she told him that he must.

Having trust in other people is something that is important for Jody, and understandable based on her sharing of past experiences, especially those with men. She typifies her life as having "alot of good times and alot of heartaches too." She has left previous relationships for new ones, and later finds herself in the same violent situation that she had left. Perhaps trust is valued because it has not been a prevalent characteristic in her personal relationships. Lack of trust produces situations (and life) that are full of uncertainty, both in her growing up years, and now as an adult. She typifies this uncertainty as "walking on eggshells," never knowing what will happen, and having to watch what you say.

A significant life transition was Jody moving from her home reserve into a nearby town. This move was prompted by a sick child, having a child at a young age, and the fact that drugs and alcohol were prevalent on the reserve and knowing "I had to get away from that." She sees that time in her life as a time when there were many changes: changes in terms of her way of living (food orientation, time orientation), and the added change of living

with "White people." This second family helped her raise her oldest son. "I drank quite a bit when he was a baby, they took him then. Today he's still part of their family." Jody has mixed feelings about the dynamics of this relationship now: "sometimes I feel really abandoned by him because he goes to them more than he comes to me, but they've got the money you know. They give him what he needs." Jody's five children are what keep her together; they are often what prevent her from returning to drinking. "I try my best with them, but sometimes I can't give them what they want." Some parenting knowledge and skill was learned before Jody had children of her own, through the teachings of her grandmother, and because she was the eldest of seven children, looking after the other children.

Social and Cultural Contexts

It is hard for Jody to go back to her reserve, especially since she has abstained from alcohol for ten years. Drugs and alcohol are major problems from her perspective. "I seen it as I was growing up and when I go back I see the same old thing except that it's another generation that's going through the same thing." She thinks about going back to her reserve because she feels there are many changes that need to be made, especially in terms of recreation. Yet she goes on to clarify: "do I need to go back, no."

Her student life allows her to learn and deal with things in "the Native way", quite a different reality from when she was in school before. When I asked her what it means for her to be Native now she responds:

> It means alot to me now. Like, I used to be ashamed of being Native because I wasn't accepted in the community that I came from because I was too dark. Most of them were a little bit fairer than I was. So I had the put-downs over there, and then when I moved into town to go to school it was the opposite, the people were the opposite. *How so?* Like it was the White people that were calling me down. I left the reserve so I wouldn't have to put up with that and then came to something that was totally new.

Jody connects put-downs, prejudice, and discrimination with her own well-being by saying that "your self-esteem and everything, you just don't have anything there anymore. And in order to bring it back you have to do alot of work."

Social support was very important during times of stress early in Jody's life. She recounts some of her experiences with her young son being hospitalized in a large urban center, and the importance of the support that she received from the family that she stayed with after leaving the reserve. "Those people that I was mentioning, they came down on the bus on their own money, on their own time. They helped me out alot, that's the only way that I made it through. Like I didn't have any support from the band where I was from."

Another dimension of Jody's social context is that of growing up poor. Jody recalls that there were times that it was a challenge for her father to keep food on the table. Growing up, she didn't have the amount of material belongings that she has now. Once she became independent, she worked for her living, and as such, was able to obtain the material belongings that she wanted. Now, due to a restricted income, she finds that couches, chairs, and beds are wearing out. Jody has sacrificed much, including material belongings to try and move out of a situation that is based on living paycheque to paycheque.

Health Meaning

In beginning the discussion about meaning of health, Jody began with "well-being" and expands this to be how people "take care of themselves, how they eat, their physical." There is a physical, embodied component to health as well, in that word such as active and energetic are correlated with health. Not feeling well is viewed as unhealthy or sick, at the physical level. And with exploration, having trouble with her husband is also viewed as unhealthy because "it really messes me up and I can't think straight." This expands health beyond the physical realm to encompass emotional and mental attributes.

> *How do you get back to that level of health, or is it something that is constantly moving and changing?* It's always different, different things I deal with differently. This morning all I did was thought about what I would do. In order for me to get back into my school, I had to just leave it, leave it for later.

Leaving for later is something that Jody believes she learned growing up. Having alcholic parents, she learned to leave things for later. Sometimes this strategy of "leaving it for later" doesn't work, sometimes life gets too overwhelming and Jody reaches a point where she doesn't care anymore, she "shuts everything down", and doesn't "deal with anything." Jody finds that she has to make time in order to work on balancing everything in her life out. She thinks that's why she gets into that dangerous zone when she doesn't care anymore, and isn't able to deal with issues. Making decisions about what to deal with is based on what is bothering her the most.

When asked about healing, similar words arise, that of "looking after oneself" in terms of "physical, mental, all those things". With prompting, Jody recounts healing steps:

> Ten years ago, I used to drink about every day, drinking every day and I had, like it didn't matter. Like I was pregnant and it didn't matter, I still drank every day. And then going into the treatment process, like that was the first step in getting some of the inner stuff that I had as a child. And strength in many ways, it strengthened me and from there on I have been taking groups, things that I need to work on. And, I bet you ten years ago I could have probably committed suicide if I kept the direction that I was going because that is where I know that I was headed for. It was in my mind, but I didn't know how. That's what kept me back.

For Jody, health and healing are interconnected and difficult to separate. She explains that in order to have good health, "you have to deal with all those things that are bugging you."

Health Problems

Jody links family relationships to health in that she feels that if relationships are good, then sickness is not as prevalent. But if she has alot of things to deal with at home, then she

finds that she gets sick more, "colds or whatever." Her current life situation gives reality to this belief.

> I have headaches, these really bad headaches, and I get my stomach pains back. I think that it is because of all the tension, and all the stuff that is happening right now. Two weeks ago, you know, I was fine. I had no headaches, I never even had to take a pill for anything.

In talking about other health situations and problems, Jody pulls in the dynamics of client-physician relationships, and perhaps, Native non-Native interactions. She recalls her mother's sickness and lack of action of the part of the physician:

> Like my mother said, she complained about being sick but he just gave her medication and sent her home, without examining her, you know, like that was all that was wrong with her. And she kept going back for the same thing. I took her in, and to find out that she had cancer. It was too far, you know, beyond where they could do anything.

Perhaps based on this past experience, Jody tries to attend physician visits with her father, acting in the role of interpreter for both parties. She worries that her father won't tell the physician exactly was is wrong, that he will misunderstand, and that the physician will not be able to explain in words that her father understands.

Bringing health problems down to a personal level, Jody feels that health problems have alot to do with imbalance.

> Like I have been under alot of stress and that, I find, it's got alot to do with all that. Like I let myself get run down so much. I don't eat some times, just coffee. It depends on what kind of mood I'm in. The only good part of it is that I've lost a bit of weight.

Weight is mentioned in terms of health and being healthy yet losing weight due to stress almost seems like a positive thing for Jody. Perhaps it is the weight loss itself that is viewed as positive, regardless of the cause.

Interpretations and Reactions

Jody was another woman that I met at the Healing Week. One of the Learning Centre facilitators told me that she was Carrier, and so I sought her out to talk to her about participating in my research. During our initial conversations, Jody talked about her family, her grandmother, her bead work, and about her daughter who wants to be a dancer. She talked as though she was a single parent, so when she later brought up her husband in conversation, I was somewhat surprised. However, learning about her relationship with her spouse and her desire to leave him, her meanings in past communication became clearer.

During our first interview I felt like I was pulling teeth. For each question I asked, Jody responded in a closed format so little exploration or depth was achieved.

> *If you think about someone that is healthy, how would you describe that person?*
> [laughter].
> *It's hard to talk about hey?*
> Ya. An active, energetic person is what I see health is.
> *If you're in the hospital are you healthy?*
> No.
> *Could you be?*
> Ya.
> *Can you talk about that a little?*
> If you're in the nospital it could be something really minor so you could still be healthy.

In the transcription of this interview, for each line of question there was one, maybe two, lines of response. I thought alot about this, and how I could draw Jody out more, so that she was comfortable talking freely. The next interview I asked her if she was uncomfortable with the tape recorder. She said that she was, but that she would like to try again with it as it seemed that the interview would be difficult with me taking notes. Over time, Jody seemed to gain some comfort and trust so that she was more willing to talk without frequent verbal prompts from me.

I knew that Jody was having a difficult time with her spouse, that she worried about her safety, and worried about being able to implement her decision that her husband must leave the house. At times, I moved more into an advocate role in asking about her safety, what options she had considered, and discussing what resources were available for her in the community.

At one point, Jody was talking about her feelings of being overwhelmed, and began to cry. I stopped the interview, and in the course of the subsequent discussion, she talked about her feelings. I shared with her how I was feeling in reaction to her tears. From my perspective, this disclosure allowed her to see that I was concerned about her emotional state, and that it was difficult for me, as I felt like I was causing her more pain. She seemed genuinely surprised by this admission, and reassured me that she always feels better after she cries; that she talks about what's bothering her. And she tells me that she hadn't cried since the last time she talked with me. I wasn't sure how to interpret that statement. Luckily, Jody went on to explain that perhaps someone is "looking out for me" because we seem to connect when she needs to talk.

I was away from the Learning Centre for almost a month, and when I returned and saw Jody I was struck by the difference in her physical appearance. It was as though she seemed "light." I asked Jody about things at home and it was then she told me that her spouse was gone, that she had "kicked him out." I think that must have been what made the difference in her presence; the fact that she was no longer feeling threatened for her physical safety, or the safety of her children.

Karen

> I never believed much in Native medicines for healing, Native medicines for curing, for getting luck or getting wealth, things like that. For me, things in life happen because that's how your walk of life is going.

Karen has lived in several small towns in the province's Northern interior. Some time has been spent on reserve with her grandmother, and as a young adult living in a common-law relationship. Karen had her first child when she was sixteen, and since then has worked toward making a good life for herself and her family. She sees herself as having many unmet emotional needs that often interfere with her ability to carry out responsibilities in relation to her school work.

Personal Context

Karen comes from a family of four sisters and three step-siblings. Karen recalls that she was raised primarily by her mother as her father left when she was quite young. Other facts she shares openly: that her mother is an alcoholic, that her father is White, and that her mother forbade anyone to mention her father's name in the house after the custody dispute was settled.

> We had no idea where he [father] was but we kept hearing from relatives once in a while that they seen him in town and he was looking for her [mother]. Those were the times that we would get curious and ask questions. And mom would get really physically violent with anyone that would ask, so we kind of learned not to ask.

Karen finally saw her father again when she was fourteen, while attending her cousin's funeral. From that point, her relationship with her father has developed over time. In speaking about trusting and mistrusting people, Karen says that "that biggest trust I have with my family now is with my dad and part of that is because he wasn't there and because it wasn't his fault [that he left the family].

Her eldest sister looked after the younger sisters alot, and from Karen's perspective, she was quite demanding, never letting the other children watch what they wanted on TV, being demanding and mean. By the age of thirteen she was smoking, doing drugs, and drinking. The next year she was "kicked out of the house", staying with friends and family. By the age of fifteen she was living with a boyfriend, then got pregnant, and "had my son a couple of months before I was seventeen." Contraception was never a topic that was discuss with her by her mother, or any of her relatives with whom she stayed.

The following passage illustrates several key points in terms of Karen's personal context. That is, how racial categories influence perceptions and relationships, and the impact of an alcoholic mother on her child:

> I had a boyfriend that was much older than myself and mom totally hated him and I don't know, she was really prejudiced against any of her daughters going out with any Native people. And that was another one of the factors in why she hated him. So she kicked me out because I was going out with a Native person and told me if I figured I knew, all the answers and knew everything, that there was no sense in me being in the same home. She wasn't there before, so it wasn't any shock for me to have a different living environment. Actually I felt more at ease I think. At home it felt like I was walking on glass. Even when we were growing up, going to the beach or the lake, out for a picnic by a creek, whatever event we had, they were happy events but they always had alcohol involved.

Transition to motherhood was aided by the support and help she received from her boyfriend's mother and sisters. She did little planning for the pregnancy, admitting that she didn't really give it much consideration, "I just took the pills and saw the doctor, and gained weight." What information she did collect was through reading, but largely mothering has been learned through experience. Along with pregnancy came the additional change of Karen "stopping everything" in terms of drugs, alcohol and smoking.

> One of the things that mom did teach us is that everything in life happens for a reason or purpose. I think this happened so that I could be more aware of how I was living my life and what I was doing with my life, to me, it was just a day to day being. And suddenly having to think more down the road.

Karen has multiple responsibilities as a single parent trying to attend school full-time. In reflecting on her roles, she thinks that she just "accepts them" because she alone was responsible for the choices that she made, and that she does her best with her mothering role. Karen also demonstrates a humbleness, saying "if my best isn't good enough, it is only because this is only what I knew." Juggling role of mother and student tends to be more stressful and more of a challenge after her kids come back from visiting their father. The rules and guidelines that she has established aren't followed when they are away, and so she must reinforce her household rules when the children return home.

Perhaps it is the simple life that she lived in early childhood, of being in the bush, hauling water and walking miles to school, or the fact that she had little money during the time that she was a teenager, that has shaped Karen so that she does not value the material. "One of my pet peeves is when people take material values too far, they value it far more than the spiritual values." In speaking about "spiritual", Karen refers to what she teaches her kids, how she wants to raise them, and the value of respect.

Along with a non-materialist focus, is desiring and striving to improve the life that she has. Most of her adult life, Karen has been on social assistance, and part of her motivation to return to school was to "get a career", and become self-sufficient. Her children have also played a role in her returning to school, "I don't want them to think that social assistance is a way of life. I want them to know that they have to work at it and the sooner they do the less stressful for them as adults with families."

Social and Cultural Contexts

Smudging[10] is something that Karen was first exposed to at the Learning Centre, and she now does this at home with her children. She said that the ceremony was the highlight of her week when she attended her program, and she genuinely missed the activity, so started

doing it at home. Karen had been given the supplies to do smudges from a medicine man about a year ago, but only recently started smudging on a regular basis. She reflects that smudging is a time when she and her three children are together, it's a time when they all listen to one another.

> To me smudging cleanses me and that whatever the smoke doesn't cleanse on the outside, I bring out in talking. I feel more comfortable and relaxed. I can just sit there and say what I want.

The practice began with Karen smudging in her room, and gradually each child joined out of individual curiosity, although her eldest child was somewhat sceptical at first. Attempting to integrate her cultural practices with her self-perceptions, I ask how being Native fits in with her life.

> The fact that I'm Native. I like doing alot of things like camping. I don't like guns but I like going out on a hunting trip. I set my own net, I have my own net. I like to go salmon fishing. And, I love the mountains and going to the mountains, cooking wild game...my band has asked me if I want a house, want a house built because I just got reinstated a few years ago. And I don't want it on the reserve, I want it on the trap line if I do get a house.

Health Meaning

Karen's health meaning focuses on the concept of balance and includes an understanding of health as encompassing "your physical, emotional, mental, and your spiritual." Having unmet needs or issues in one area of self can lead to a feeling of emptiness and being out of balance. These times are seen as vulnerable times when stress can be more pronounced and more challenging to address. Karen makes the connection between health and stress in this manner:

> The little things and big things that happen in your life that make your lifestyles changing for a day or two, or weeks or months or the rest of your life, can add strain. And coming to accept them is probably one of the hardest things to do but it's probably the only thing you can do sometimes.

When asked to describe someone that is healthy, Karen explains this as someone that is self-aware, and happy with that. Being self-aware is being emotionally and physically sound, and with this state, there is little room for stress to infiltrate. Being self-aware is also knowing "what you want and how you want things to be."

Controlling her own health is mediated through two main strategies: eating healthy and living healthy. Elements of these strategies are exercising, watching what you eat, and getting proper rest. Karen links the complexity of her own understanding about health to her current self-assessment:

> I find that things in my life aren't balanced right now and it's, especially my emotional part of me, so I don't feel, because they're not balanced and I'm affected emotionally that I'm not getting the physical rest that I need, I'm not getting things that I should be getting for myself [eating properly and quiet time].

Rest is something that Karen is not getting enough of, and the consequences are that she feels physically drained, and feels that even going for a walk is "like a big effort."

Interpretations and Reactions

Going over the consent, Karen asked me about the section on how the researcher contacts potential participants. She was especially curious about the sentence "your name may have been given to the researcher by someone at the Centre..." In response to her question, I clarified that the third section of this sentence applied to her, in that I contacted her directly to be interviewed. I found this somewhat curious, but did not explore further with her why she asked about this specific section. I did question myself about why she might be interested specifically in that section of the consent. From Karen's perspective she might have wondered if one of the facilitators in the program had asked me to contact her. If this was her thought, then holding this assumption through interviewing could have been detrimental to both the type and amount of information that Karen would choose to share with me. Karen's

questioning may have an underlying basis in how much she would trust me. Reinforcing that I had contacted her directly may have allied the fears that someone had asked that I talk with her, and help establish some initial trust in our relationship.

Karen seems to be at a difficult point in her life. She readily talks about her family, her relationships with her mother and father (divorced), and about her young adult years. Yet it seems that she is on the verge of tears most of the time, and at one point, I stop the tape for a brief time, and then move on to another subject area. I get the sense that there is alot more going on with her than she discloses, yet I cannot force myself to confront this perception with her. It is almost as though she is fragile, and so I use my intuition and give her her space. This is the reality of the research role, in some ways I suppose, in that I am a guest; that I have an ethic of "do no harm" and respect where each person is at, at a given point in time.

When asking Karen about her feelings of interviewing, she relates that she didn't "think it would be this hard." She does not have the words to explain why it is hard. And perhaps in a vicarious way, she confron[illegible]own, some of the issues that she would not talk about with me.

> Strength is someth[illegible]n your heart. Strength talks to me of just holdi[illegible]just being, you know, being able to move through life[illegible]o hold onto your values and beliefs, and to not let people sway [illegible]ean, lots of times it would be easier if we swayed a bit. Strength is different as you mature, as you experience, have different life experiences, and personal relationships.

Monica is a middle-aged woman with a certain presence about her, that of strength, and perhaps of power. She talks freely about her life, about her past relationship, and about her self-reflections. In her talk, there is a certain humbleness, of an understanding that she can use her personal experiences in order to relate better to other people. She works full time at

the Learning Centre, and is active within her community. Monica is in her second long-term relationships. Two grown children and a grandchild complete her immediate family.

Personal Context

Monica begins her story-telling about her life as always having to be in control, and having alot of responsibilities. She is the eldest child, and left home when she was fifteen. A year later she had her first child. "I've always been in a role where I have had to be very, very strong and together, and in control of things." Monica's mother is Cree, her father White. "I identify quite strongly as being a Native person but I also respect very much, the heritage and culture of my dad's side of the family." Monica continues in her recollections of childhood:

> So when I was growing up, you know, there was a fair amount of drinking in my family. And uh, I don't know if you have ever heard the term of people "going Indian" but that described my mother when she was drinking. And I think that she took alot of her frustrations out on the children. And because I was the oldest, I sort of was the buffer I guess, during those frustrations. I can also remember my mom and dad both fighting alot during the time that they were drinking. You know, it wasn't always my dad that was beating up my mom, it was the other way also.

In her early teens, Monica had an experience that influenced the way that she lives her life, an experience that caused her to vow to herself that she would never be involved with drugs or alcohol. And she has maintained that personal promise. Yet she moved out of an alcoholic home into a relationship with a man who got heavily into alcohol, drugs, and did a fair amount of jail time. Monica sees the contradiction in the fact that she views herself as strong, yet thinking that some of the dysfunction in this first relationship was because she "took care of things all the time." Taking care ranged from daily tasks around the house, to all the child care responsibilities, to the finances.

Her married life was turbulent, dealing with a physically and mentally abusive husband, getting up enough courage to leave for short periods of time, and at times, not having

much stability in terms of income. Monica spend short periods of time on social assistance, but found the whole thing "humiliating" and "difficult".

> You are just trying to make it from one paycheque to the other and you know, sometimes I would be so scared, like if the kids got sick, that I wouldn't have money to go and buy Vicks or Tylenol or, I used to be scared when they were growing and out-growing their shoes. I would just panic, because I didn't have the extra money, you know. And of course I didn't know much about the system then either, because like, lots of people do all kinds of things and they seem to know the system and I didn't. So it was a frightening experience for me, and just not being able to, you know, things like Christmas would come around and I would just dread it.

It is from past experience that Monica has developed a strong sense of "working for what you get." Working at times was her sanity while in her first marriage, otherwise she fears that she would have turned to the "same sort of behaviours that my ex-husband did."

Her two children, along with the rules that she set for herself were the walls that kept her life together then. "My children are so important to me, they really are. And we have lots of struggles, you know, but I am probably sitting here today largely due to them." Monica talks about the fact that she attempted suicide twice in her twenty year marriage, yet she feels her children were her grounding during those times.

For Monica, she struggles daily with coming to terms with who she is, of letting go of the feelings of shame and humiliation from a failed marriage, of wanting to be accepted for who she is.

> There were different things that happened that really turned things around for me. You know, in terms of just an awareness, because it is almost like, because I was so young when I was with my ex-husband, that it was like he moulded me to be this person that he wanted to see. And it took those different things in my life to kind of go, "oh", and for me to have more of an awareness of who I was as a person.

She learned early, both through her childhood and into her married life, that in order to survive, it was best not to talk about feelings, emotions, or opinions.

> Because at the time, if he [ex-husband] was sober, he might sit and listen to me, but if he was drunk, then I would get it. It was like walking on eggshells all the time. And so, I learned early on in the relationship to keep stuff inside.

And there came a time when she realized that she no longer loved her husband. This realization was the catalyst that gave her the strength to end the relationship. From that point, Monica has been evolving, finding her own voice, her own sense of who she is. Monica also speaks of acceptance, accepting herself and her dimensions of self, as this is the first step before others accept the same.

Monica describes herself as being on a healing path, and that she takes one day at a time. Integrated into most day's routines is some degree of self-talk that often goes along with smudging. Another part of her healing path is thanking the Creator for her experiences; instead of feeling sorry for herself and internalizing that, she is learning and growing from her experiences. "So I try and turn things around for me in the way that things are best for me." Even now, Monica feels control from her ex-husband, and that angers her "because I feel that control is related to fear, so, you know, that's something that I struggle with and I have to face that, and am challenged by that every day."

Safety is a theme blended into Monica's discourse. She speaks of being safe now in her relationship with her second husband, of her learning that she could manage on her own after leaving her ex-husband and being relieved that she and her children were safe. Safety is also raised in terms of relationships with other people. Monica recalls that she didn't have a close friend for the first fifteen years of her marriage because it wasn't safe to do so. Eventually, one friend grew to three, and the four women developed close and lasting friendships. These friends never told Monica what to do, but rather were there for her, they fostered her emotional well-being. "It was unconditional acceptance and friendship. And to me that meant so much because I had never had that."

Social and Cultural Contexts

For Monica, feelings around being Native and identifying as being Native have happened fairly recently. "I haven't all my life felt good about being a Native person, it hasn't happened that way." Over about the last five years, her Native identification has developed more strongly. Monica has been involved with working with Native people for many years, and many of her role models are Native people very involved with the "cultural aspect of being a Native person." A friend of Monica's did some work with her and she shares this:

> The way she talked to me is that when you're involved in the cultural aspect, is that it's involvement in a way where you don't judge people. Where you respect people for who they are and you allow them their dignity, and for me it fit. Because that is what I wanted, I wanted people to accept me and I wanted people to respect me and allow me my dignity and to be who I am. And that was something, I guess, finally when I talked to her I heard that but it was something that I wanted for here [points to heart] all of my life.

Integrated into the cultural aspect of living, from Monica's perspective, is the spiritual dimension. She has been involved with sweats, smudges, and spending time learning from spiritual advisors. Even walking in the woods is something spiritual. She listens to elders anytime that she has the opportunity. And she speaks with her mother "in a different way than I ever did before." She welcomes this spiritual aspect into her life, as something that she wants, and something that she knew she was ready for.

When asked what culture means, Monica describes culture as "being able to say that I identify as being a Native person." She doesn't view herself as any different, and sees part of her culture as being a person who "doesn't make judgements about other people." Smudges and sweats are part of what Monica defines as spirituality. She thinks that at some point, the cultural and spiritual aspects of who she is may be more integrated, and for that, she will have to do additional learning, seeking out more knowledge about her people [mother's family].

Finding out about specific practices, dances, artwork, dialects of speech for different Cree bands is necessary before spirituality and culture could be meshed in a respectful way.

Health Meaning

When I ask Monica what health means to her, she responds that "it means well-being, my personal well-being." Monica goes on to give an example of this. When she was in her first marriage, she felt quite healthy in physical terms, but in terms of her well-being, she wasn't healthy at . Now, in her second marriage, she feels that this situation is reversed, that she is stable emotionally, mentally and spiritually, but her physical health has been impacted by her previous relationship. Monica feels strongly that her health is affected greatly by her emotional and mental well-being, that stress has influenced not only her self-esteem and self-value and self-worth, but also some of the physical symptoms she has today. These beliefs have been validated by her physician, and she recounted that "some of the stuff that is happening with me now is a direct result of stress, many, many years of stress."

Monica's spiritual side has had a large impact on her sense of emotional and mental well-being. Finding out about who she is has been a spiritual experience for her, "like a light at the end of a tunnel." Monica goes on to say "not just I found God or the Creator, but just all of the things that I have been looking for to tell me who I am, and that I'm a good person."

Spiritual, mental, emotional, and physical dimensions of self are all equally important to Monica. "It's more of a balance for me I guess." Not too long ago, she had so many things happening physically that it just kind of took over my life." There have also been times when emotional issues have been at the forefront. "But I think that I'm getting better at dealing with those and the periods of time where I change from one to the other aren't as great." By this, Monica is talking about the times where one dimension of self "takes over"

and she feels that she is improving on her ability to keep more of a balance. For her health Monica knows that she needs physical, mental, spiritual, and emotional dimensions balanced.

> And for me, there are lots of times when I am sick and disease-free, but I still don't feel like I'm in really good health because mentally and emotionally I'm not feeling that way. So, to me, that says that I'm not healthy. But sometimes I might be, it just depends on where I'm at that particular time.

Describing health and healing is seen as impossible for Monica, as she explains that health and healing mean different things to her at different times. Being on a healing path means that she is "moving on a road that talks about the well-being of me, whatever that might be." And this path, this journey, involves choices and decisions that will get Monica one day to meeting the Creator. Monica sums up the relationship between health and healing in this way: "I don't know if there is a difference, sometimes there is, sometimes there isn't." However, in order to move on a healing path, people need to be healthy both emotionally and mentally. Being unhealthy physically does not prevent movement along the healing path. And perhaps this is explained further in Monica's comment that "if I still felt safe and I still felt accepted and I still felt loved, I would still feel healthy."

In speaking about disease, Monica again approaches this from a holistic perspective, believing that "your emotional and mental space has alot to do with how you are going to work your way through that [disease/illness]." She admits that she finds the concept of mental illness confusing as she believes that individuals have a great deal of choice in how situations are dealt with, and that people have alot of control over their bodies. Perhaps this belief is in part based on her own experience of controlling her body, disallowing her body from being ill or manifesting disease or illness until she felt that it was safe to do so.

Health Problems

Monica feels that the stress and abuse she has encountered has markedly affected her health, in that "all those years of tapping stuff down and living in a stressful situation, I am

responding to it." Her response is that she has been sick frequently over the last two to three years. In talking to her physician about this, his perspective is that she is now in a situation where she is safe, and so the catch up is occurring.

In her first marriage, Monica recounts that food was her comfort; that she was not able to talk about her feelings so food became her substitute. "When I was unhappy or angry or whatever, I would eat." Her husband reacted to her gaining weight, and blamed everything he did on the fact that Monica was overweight. Monica got so that she was sneaking food, and hiding food as a way of "dealing with what was happening within me." This issue of weight has been a catalyst for additional health problems that she deals with in the present. Struggles with eating and weight continue now, and she attributes this to her eating behaviours becoming an addiction or habit.

Monica recalls that in her young adult years, it wasn't acceptable to be sick. Even after having surgery, she couldn't lie down on the couch when she wasn't feeling well. Now if she is not feeling well, she goes home and lies down, and if her husband has to make supper, that is okay.

> Back then it wasn't acceptable. I would get things like you're a hypochondriac, or stop whining, that sort of stuff. So you know, I guess I say that I was healthy then and I wasn't now and it wasn't really that way, but in terms of it being acceptable, it's like the difference between night and day.

In addition to the element of permission, Monica describes links between her physical self and emotional/mental realities. She relates that earlier disease and subsequent operations can be attributed, at least in part to "my body sicking, and the stress, and you know."

With the help, love, and support of her husband, Monica is changing her strategies so that instead of pushing illness and sickness away, she is facing her health-illness situations and acknowledging that she has to do something about them. She admits that she thought that her health issues would "just go away", that if she just "forgot about this, it will be better." Now

Monica is addressing her health issues, believing that they are things that she can do something about and being convinced that she is going "to get better." For this to happen, Monica is melding the physical issues more with her mental, emotional, and spiritual dimensions of self so that there is more of a balance, perhaps an acceptance that the chronic health issues are not going to just go away.

Interpretations and Reactions

I thought a long time before asking Monica to participate in the research project. I thought about the fact that she appears consumed with work, and that she has very little time for herself. But I also explored my hesitation in asking her participate. It wasn't that I was worried that she would say no, I think it was more that I was intimidated by her. Monica's presence reflects personal strength, and her interactions with others mirror this. And I think that I was somewhat taken aback by several comments that have persisted in my mind over time. One such comment occurred at the Healing Week, when I said that it would be a good week. To that, Monica responded "I know." In reflecting back, I now see this comment in it's context. Monica has a very strong sense of spirituality, and she also has had visions allowing her to see some parts of her future. She believes strongly in the Creator, and at times, talks about the Creator's agenda. So the comment "I know" may mean that she was confident that the event would be a success because it was planned with a good heart, and it was done in a "good way." Knowing that some activity is done in a good way is subjectively based on the understanding of intent for those involved with the activity. What is viewed as being done in a good way may be different based on the person or people involved, and can change over time (fieldnotes).

With Monica, I felt that I did much more self-monitoring in terms of the questions that I asked. I had a difficult time getting questions out because I was thinking about how Monica

would interpret them. At one point, Monica was talking about how spirituality is so important in her life.

> *How did that process of, or was it, I am always worried about my questions because I don't want to put words in your mouth.* Don't be, just be upfront [laughter].

The self-monitoring I did may have been based on my perception that Monica is very insightful, and that she is also very self-aware. Perhaps I perceived this as threatening. Yet to me, this was a contradiction in my own approach to research participants; I valued them as the teachers and me as the learner.

I worked with Monica on several small projects at the Learning Centre, and at these times I did not feel the same level of self-monitoring. But the context and situation was different. In many ways, research is an extension of one's self, of one's values, and interests. So from my perspective, I was sharing more of myself in interactions with Monica within the research situation.

My perception is that Monica is a very devoted and giving person, sometimes at the expense of her own physical health. In Monica's discourse there was depth of understanding not readily apparent in other women's talk. I wondered if this is the additional time that Monica has for herself now that her children are adults; a luxury that the other women don't yet have. I was able to clarify this thought with Monica: "Oh ya, I have alot more time now. For example, my kids don't live at home now, so I have that time. I certainly have that time."

Summary of life vignettes

From the information recounted above, the lives of the women are complex. Yet there are similarities in their stories that I would like to extract and summarize. These similarities are: working or attending programs at the Centre, being of Native heritage in a predominantly

White society, working at living a "Native way", and being influenced at a personal level with alcohol issues. The experiential and contextual similarities can shape the way that the research participants see and do, that is, their way of being in the world. Each of the life similarities will be addressed in turn.

First, the women involved with this research all work or attend programs at the Centre. This means that they have made a personal commitment to either being gainfully employed, or to beginning on a path of self-improvement through seeking out formal learning opportunities. For the women that are employed at the Centre, they too have been working on their self-improvement in order to get into the positions that they currently hold. One woman has been involved with the educational system for a number of years, acting as a liaison between the school system and Native students and their families. Another woman began at the Centre as a student, and is now employed with them as a facilitator in one of the programs. What this commonality of environment allows is that all of the women are influenced to some extent by the culture of the Centre, and the relationships that they establish with people at the Centre. Whether or not each woman is "like-minded" with what is set out as organizational culture is not at issue, but rather that each is exposed to this culture in explicit and implicit ways.

Second, all of the research participants are Native women living in a predominantly White society. The "ruling race" (so to speak) are of European decent, and the historical relationships between Native peoples and Europeans is fraught with issues of control, imposed assimilation, and exploitation. These issues can very well influence current race relations, especially given the Native surges to reclaim what is rightfully theirs as First Peoples. Linked with the reality of not being of the predominate race is that based on Native heritage, each woman holds cultural values that shape her thoughts and actions. The cultural values that each woman holds may be somewhat in reaction to avoiding negative stereotypes about Native

people, and Native women specifically (e.g., that Native people are "dirty", "drunks", and Native women are "squaws" - as a commodity to be exploited). All of the women recount some level of struggle based in conflicts that often originate in differing cultural values. An example is how just recently these women have found strength in their Native heritage. Previously they worked at fitting in, and ran the risk of being labelled an "apple Indian."

Third, because of their working or school environment, there is an emphasis on trying to live "the Native way." For some women, this has become well-integrated into their daily lives so that it includes their personal selves as well as their social selves. What is pervasive in this "Native way" is being non-judgemental and working as a community. An example of this is the talking circles that are used in each program. The talking circles are a way of connecting people in the class at a personal level, and visibly giving recognition to the entirety of self, not just cognitive dimensions of self. Talking circles are a way of verbalizing feelings and sharing, and through these activities, community is built. In some ways, this reflects the concept that everything is inter-related.

Fourth, all of the women who participated in this study have either had alcohol issues in their own past, or family members who have had alcohol issues. For Margaret, both she and her husband used to drink, but she quit the last years of her marriage and continues to abstain. Karen, Monica, Janice, and Jody all share stories about growing up in an alcoholic home, where they felt that they were "walking on eggshells." Monica had a partner that abused alcohol, and Janice's husband continues to deal with alcohol issues. An underlying current in discussions about the effect of alcohol on their lives is somewhat of a fragmentation of the self, where self-esteem is described as being low, and where living in an unstable environment produces feelings of uncertainty, and lack of control.

Examining similarities of contexts provides four foundations on which shared meanings can be based. For the women involved with this study, their areas of overlap in terms of shared meanings are being involved with the Centre, being Native in a predominantly White society, working at living in a "Native" way, and dealing with alcohol issues.

CHAPTER 4: Patterns of Meaning

Overview

A number of strategies were employed with this phase of data analysis. Initially, key words were extracted from each woman's individual interviews and developed into domains (Spradley, 1979). I found domain analysis too reductionistic for my liking as language was limited to single words. However, including this step did prove valuable as it was a means of dwelling in the data (Hammersley & Atkinson, 1984) and a starting point for seeking out similarities in narratives. With additional readings of the interviews, domains from each woman's narratives were recontextualized in my mind, and examined together with other domains found in other narratives so that the totality of domains were viewed together. With recontextualizing and viewing in totality, similarities and commonalities became apparent in the talk of the participants. These commonalities are broader categories that cut across individual women's stories, in effect, providing cross-case similarities when each women is viewed as a case (Yin, 1994). I have termed the developed commonalities patterns of meaning to reflect the essence of this phase of analysis, that is, the discovery of meaning in context.

Patterns of meaning are the themes of women's discourse that provide insight into the complexity of health conceptualizations and also provide context to discourse around health. In beginning to examine patterns of meaning, I observed that health discourse began as a small circle, and with subsequent discussions and ongoing relationships between participants and myself, the health discourse blossomed to a multi-dimensional representation of a life circle grounded in these women's daily lives; their insights, reflections, achievements, and challenges. Emerging from the data are four patterns of meaning: responding, surviving, healing, and good/bad medicine.

Responding

Responding is the actions and reactions of the embodied self in constant interaction with internal and external environments. Environments in this sense are not only used in its common meanings but also are encompassing of social, political, and economic worlds of individuals, their families, and their communities (Stevens, 1991). For some women, responding is a way of reacting, for others it is being proactive when change is seen as necessary, or when change is a personal choice. There are several meaning threads in the pattern of responding. These are: body responding, taking care, needs for self, and pushing away.

Body Responding

The thread of body responding is the outcome, or the result of, the interface between personal being and that of the external environment. In this sense, external environment is conceptualized as that outside the personal self, and may include relationships with others and physical environment (e.g., work building). Body responding is also inclusive of the interaction between mind and body, and even within personal dimensions of self such as the interplay between spirituality and sense of self.

The physical body can manifest reactions and responses to past experience through body signs. These body signs may be ignored or suppressed until such time as the emotional and mental dimensions of self portray a sense of safety and acceptance.

> Monica: I used to be a pretty healthy person, but now my body is saying to me, you know, all of those years of tapping that stuff down and living in a stressful situation, I am responding to it.

Suppressing body signs can lead to forced decision-making when in different circumstances, a decision would be postponed. Depending on the salience of the body signs, choices and decisions in relation to the body signs can be avoided for long periods of time. If the body

signs are apparent and break into the emotional and mental dimensions of self, decisions are mandatory and incorporation of a certain bodily reality may be essential.

> Margaret: Choices that I've made so far influence what I'm going to do next, like this surgery. Like, health wise, up to now I've been putting it off and now it's gotten to the point where I could be in big trouble, you know. I have to make some real decisions, it's almost like a crisis. I'm at the edge and I have to make a decision one way of the other or the decision is made for me almost.

> Monica: So for me, those things [my physical well-being and my emotional well-being] have come together and I'm facing those things rather than thinking, "oh well, I can't be sick, I can't have this happening because of this." Now I'm facing it and saying to my husband that I've got to do something about [these things], and talking about them. *And what you're dealing with are chronic medical issues, they aren't going to go away.* No, right. But I thought they would. I thought if I just forget about this it will be better [laughter].

Relationships affect and mediate responses of personal self in terms of self-perceptions, self-esteem, and self-valuing. Body responding links the role of relationships with the presentation of self both in cognitive and affective domains. One woman explains this reality:

> Jody: *How does your family influence your health, or does it?* I think it does. Like, if you're on good terms. I find myself not getting sick and stuff. If I have alot of things on my mind, what is happening at home, I get sick more, colds or whatever. Trouble with my old man is unhealthy for me because it really messes me up and I can't think straight.

In the above exemplar, Jody refers indirectly to the connections between mind and body. Mind and body are connected in intricate and unexplainable ways. The research participants acknowledge connections between mind and body, and in this acknowledgement is an accepting that mind and body cannot be teased apart for analysis at one level, and at another level, the two can be spoken about separately for ease of explanation. All of the research participants either directly or indirectly address body-mind linkages, so that in these references, mind-body integration reflects a holistic understanding. Karen tells a story about a video she saw in class about a woman who has cured her cancer due to positive thoughts.

> Karen: I find that somewhat far-fetched, like this women that cured her cancer because of her healthier thoughts, and I find that hard to believe because cancer is something that eats away at your body. And I don't think it's something that applies to everyone, like, it may have worked for her, God knows why [participant laughter], but you tell another person to do the same thing, it might not work for them.

Here Karen underscores the individuality of health and healing, in that what works for one person in terms of body-mind connection may be ineffective for another person. Mind and body connections are also coined in phrases like "mind over matter." Working through disease, illness, or crisis can also exemplify the intertwining of mind and body.

> Monica: When I was in my situation in terms of health and disease, I felt that my body was the only thing that I had control of. I really do feel that we have alot of control, like our minds have alot of control over our bodies and how our bodies are going to respond and react to different situations.

Karen and Monica both talk about mind-body connection, yet their frames of reference differ. Monica relates self-determination, choice, decisions, and control in her discourse of mind-body. Karen, on the other hand, feels that she often must accept situations as this is sometimes the only thing that she can do. There is almost a note of resignation in Karen's talk. She brings in her environment and historical self by saying that "one of the things that mom actually did teach us was that everything in life happens for a reason or purpose." Karen's internalizing a learned determinism approach to life can also help explain her inability to believe that the mind can eradicate a cancer that inhabits the body.

Taking Care

Taking care is the action of assuming responsibility for, or looking after, self or others. Taking care is seen as an act of control for some, and it is also a way of managing health and disease. There is on ongoing process of taking care, not that of take care, but rather the actions that occur over a period of time. Taking care has overt elements of responsibility, as

well as implicit knowledge about what is right or wrong. Knowledge becomes integrated into an understanding that guides actions for health.

> Monica: By saying that [I have this disease], it's saying to me that it's important not to stress myself out by keeping things internalized. Because it's almost like when I loose sight of that, I go back to my old behaviors of internalizing things, of taking care of everybody, or rescuing, or being a strong person, and being in control all the time. And I can never do that again. Because I see that as not being a healthy thing for me.

Not taking care is manifest in a cycle of stress that results from continual worry about situations, people, or opportunities.

> Janice: You know, the stress. I feel anyway, that your body gets run down, you worry and think about things so much that you forget about yourself and then it catches up with you, in the way of getting sick.

> Janice explains about her mother: She does keep up with her medications, but I don't feel that she's all that, she not as healthy as she could be. I don't know if that is part of what is happening with dad that she's let herself go so much. She did that when her mom died; she was very close with her mom. And when she died, that is when it seemed that she let herself go, she didn't really watch.

> Margaret: When I worry I don't look after myself properly because I go farther than I should. I stay up late and don't eat right.

For those with medical issues, taking care is operationalized through such activities as medication usage, and for others, it is the avoidance of medications. Medication usage is monitored and adjusted in order to take care of self while incorporating physician advice, to some extent. An understanding of variation is implicated with taking care in that individuality is maintained and choice is also incorporated.

> Monica: I think that there are drugs out there on the market that aren't good for you, and that you shouldn't just go in there blindly, the doctor says you should take this, so you take it for the next twenty-six years. I think it all talks about making informed choices for ourselves and asking questions and being educated about the choices that we make for ourselves, whatever those may be.

How an individual goes about taking care is dependent on the perception of the situation, the problem(s), and options for resolutions. Thus taking care can take on a multitude of forms and address any, or all, of the components of self, including spirituality. For some authors, spirituality can be described as the unifying life force, or vital principle of a person (Nagai-Jacobson & Burkhardt, 1989) and as such, spirituality is essential for health and well-being. Thus, taking care in a spiritual sense could encompass actions in other dimensions of self (e.g., physical, emotional, or mental) or could involve such activities more in keeping with a defined spiritual activity such as being with Nature, or quiet time. Taking care spiritually may also mean attending to self-reflection, religious practices, or coming into a relationship with one's experiences (Burkhardt, 1989).

The doing of health

A facet of taking care is the doing of health. This encompasses the shoulds and supposed tos that individuals learn through socialization, media, health professionals, family, and peer groups. The shoulds and supposed tos can form folk knowledge that then becomes the foundation for health actions and activities. However, the shoulds and supposed tos are the limits and structure imposed through ideology, and therefore may not fit with cultural norms or individual reality. It is the breakdown or conflict between the social ideology of shoulds (norms) and individual reality, or lived experience, that may inhibit incorporating ideology and thus prevent health action.

Subjective and objective dimensions of health may be mediated to some degree through the doing of health. Perceived health status may be based on self-assessment in reference to common statistical norms, such as ideal weight range for height. Examples of the doing of health are such activities as eating right, exercising, getting adequate rest, talking about feelings, and incorporating quiet time (this allows for opportunity for reflection as well).

> Karen: I'm not getting the physical rest that I need, I'm not getting things that I should be getting for myself. Eating properly I guess, and I used to have alot of quiet time in my life and I don't seem to have that anymore.
>
> Jody: [I don't consider myself healthy because] I haven't been eating the proper foods that I am supposed to, that I know I should be eating. Just not in shape. Smoking, I feel that is really unhealthy.

The doing of health can be restricted through such realities as lack of time, multiple responsibilities, and financial status. Using a large random sample of urban women, Verhoef and Love (1994) conclude that mothers overall are less active than childless women. Their findings focus on lack of time due to family obligations as the most important barrier to exercise for mothers. The discourse of the research participants affirms how life complexity constrains or promotes how thought is transformed into action. Life complexity is the intermediating layer between personal reality and sanctioned social behavior, whether it relates to coping, health, or disease management. The following two exemplars explicate how the doing of health in relation to eating right are constrained by time and money. Janice works full time, and often her husband is out of town. She is the one primarily responsible for her children's daily needs.

> Janice: I realize that I can't do this anymore, going to McDonald's and eating greasy foods, but then I, I guess I don't. It seems that there are two sides of that for me. I say that I don't want to do it and I feel bad about doing it, but it is just so much easier to do than go home, or go to the grocery store and pick up the proper groceries that I would like to eat and then go home and cook it - I am looking at, like, 7 o'clock. So time is a big factor too, in relating to health and other things that I would like to cook for supper. Like more salads, boiling things instead of frying.

Margaret is solely responsible for her children's daily needs. She has been divorced for about six years. "When I first left my husband, I had a hard time keeping food on the table. I had a hard time learning to budget my money so that they had the right amount, the right kinds of food on the table. It was hard with milk, fresh fruit, and vegetables for the whole month because I was on assistance [income assistance/welfare]."

Weight

A salient thread that permeates discussion about health for the women participants is the subject of weight. Weight relates to taking care as it is linked with diet and exercise, and in some manner, may be viewed by others as the most significant objective dimension of taking care. Weight is the reality of some women that must be constantly negotiated based on their own self-perceptions and the perceptions of others. Ideology plays an active role, although often hidden, in how the meaning of weight is integrated into self. Normalcy is defined in terms of weight, and health can be viewed through self-perceptions and others' perceptions about what constitutes normal weight. Norms are prescribed by often unrealistic ideals, and one continually compares self to these ideals as standards of measure.

Weight has definite links with emotional sensing. For some women, the perception of being overweight leads to feelings of unhappiness, depression, or even disgust.

> Margaret: Anyway, I have gained so much weight I have started to feel really disgusted with myself, I have to get myself down again. You know, like, I have in my mind that since I gained weight I have become down on myself. I have alot more health problems like with the asthma, and I am lazy. I just get lazy when I get bigger, fatter.

In this exemplar, Margaret is also seeking meaning, trying to make sense of the relationship between weight and feeling. Yet the subjective meaning that she gives to being overweight becomes the predominant force in creating the meaning for her feelings. She has a discomfort with laziness that is apparent in the tone of her voice and how she moves from word usage from "bigger" to "fatter." The influence of ideology, of the "ideal thin woman," creates the structure by which she generates meaning and internalizes discrepancies between her reality and her personal interpretations of social prescriptions.

Ideology about weight and health may also lead to such behaviors as eating disorders. For Monica, eating was a way of taking care of herself when she perceived that she had no

other avenues through which to deal with emotional issues. Now that her environment has changed, she continues to deal with her own eating behavior because she has formed certain eating habits.

> Monica: You know, I never ever drank or had done drugs, but my comfort was food. And when I was unhappy, or angry or whatever, I would eat. And my ex-husband was one of these people that got on my case all the time. Everything he did was because I was overweight, you know, he fooled around because of that, he drank because of that. So consequently, you know, when we were having problems of any kind, like I would even sneak food. Like, I would buy food and put it in the bathroom. Or go in and turn on the shower and eat, you know, that was, for me, a way of dealing with what was happening with me.

It is difficult to assess the influence of prevalent societal norms for these women. However, they are living and working in an urban environment, and in many cases, are subject to the same factors that perpetuate thinness as desirable (e.g., primary media sources like television, magazines). Yet for some, depending on the community connections that they have and the value that is placed on words of older people (for this group of women, that would be Elders), they may receive contradictory messages in application to body imaging and weight.

> Janice: I have gained much too much weight [laughter] and it has affected me in my more complicated self. *[and then later the contradiction]* And alot of what I am hearing now is to be happy with who you are, if you're not happy with who you are, you'll never be happy.

In examining select literature in relation to weight issues and body perceptions, it is apparent that there has been a bias towards conducting research with White women. Research is beginning to emerge on eating disorders, weight issues, and self-perceptions with cross-cultural samples. One survey (N=85) was found that studied Native women (Rosen, Shafer, Dummel, Cross, Deuman, & Malmberg, 1988). Findings of this study showed that 74% of respondents were trying to lose weight, and of those women, 75% were employing potentially harmful techniques (almost one quarter were employing some type of purging technique such as self-induced vomiting or laxative use). What the results of this study demonstrate (though

tentative), is that Native women are not unaffected by the majority Euro-Canadian culture that perpetuates ideals of thinness. A second study with African-American women reveals that "African-American women experience some degree of body size distortion and dissatisfaction. They have at least partially adopted the "thin is beautiful" ideal of their White counterparts, which further increases their susceptibility for the development of eating disorders" (Pumariega, Gustavson, Gustavson, Motes, & Ayers, 1994. p. 12).

Bowen, Tomoyasu, and Cauce (1991) review the race, class, and gender literature in relation to weight issues. The perspective that they put forward is that poor women of color are more apt to be overweight than middle class White women. Women are often stigmatized for obesity and experience dissatisfaction, even depression, due to sex-specific pressures pervasive in society (Bowen, Tomoyasu, & Cauce, 1992), and constant striving for unrealistic goals (Clarke, 1989). Feelings and reactions to being overweight often center on a control issue. Those reacting to another's weight may naively believe that one can decrease her weight by simply exercising more control over eating behavior (Bowen, Tomoyasu, & Cauce, 1991). Societal perception that obesity originates in lack of self-control may be linked with the Western philosophy that separates mind and body, and views the "unruly body" as something that requires self control and mastery over (Sault, 1994).

Additional research examines cultural differences that may influence weight and body image. Within the African-American population, ideology exists that values improvisation, creativity, and style (Parker, Nichter, Nichter, Vuckovic, Sims, & Ritenbaugh, 1995). These values foster a "using what you've got" perspective that produces fluid definitions of beauty, and because of this, personal ideals may take precedence over striving for abstract (and often unattainable) ideals (Parker et al., 1995).

Needs for Self

The thread of needs for self, in the pattern of meaning of responding, incorporates the interface between self and others as manifest in multiple roles and responsibilities. Needs for self are the needs and desires of the women participants that often go unspoken, and if spoken, often unheard. This is the search for self-identity separate from that of mothering, or being a wife, or an employee, or student. One women frames needs for self in her discussion of self-satisfaction, a looking for something that she has not yet reached.

> Margaret: I always seem to be pushing myself. And maybe that's what I'm looking for is that little bit of time for myself, because I always feel like I am looking for something, reaching, and I push myself to a point of self-satisfaction but I never get there. I'm stretching myself too much.

For Margaret she continues to struggle with what her needs for self are, and this is the process of learning to acknowledge her own needs, as separate from those of her provider role. In talking to me when we first met, Margaret spoke of "doing something for myself" as she realized that her whole life and living revolved around her children (fieldnotes). With her eldest children soon to become independent, she faced this reality and chose to move ahead on her own path by enrolling in a education program.

For other women, needs for self are linked with trying to maintain a sense of balance in their lives. Janice shares her perspective:

> Janice: I want to do some of the things that I did before the kids came, activities like ball, going back and playing. Get that fun stuff back in my life. My husband has it, my kids have it, now I want it.

Tied in with needs for self is an underlying valuing of self that some women are just beginning to incorporate into their ways of being in the world. This insight is the stark reality that self-identity and self-perceptions are not based solely on what one does, but also incorporates who one is. Here the dichotomy between being and doing may be apparent for

some women. Several women spoke of wanting more spirituality in their lives. One women speaks passionately about the role of spirituality in her own life.

> Monica: The spiritual element of my life has really had a large impact on that [where I am today]. And it hasn't, by any stretch of the imagination, been a crutch. It's just an understanding. When I say spiritual, I don't necessarily say spiritual as in black and white, like God and the Creator, I just mean about, you know, like finding out who I am has been a spiritual experience in that it's been almost like a light at the end of the tunnel [pause], just all the things that I have been looking for to tell me who I am, and that I'm a good person.

Valuing of self is similar to what Burkhardt (1992) defines as the relationship with oneself. This relationship is part of a larger system of relationships that characterize spirituality. The core of the relationship with oneself is the "sense of atonement with one's inner resources or strength" (Burkhardt, 1992, p. 15). For the women in this study, recognizing inner resources may be facilitated by solitude where the focus is on being rather than doing. However, solitude is a reality not easily found in the lives of the research participants due to multiple responsibilities. Monica seems to have the most developed relationship with herself, and this may very well be that she has the opportunity to take time for solitude and reflection.

In keeping with the relationship theme that often drives needs for self, perceived lack of social support may also foster an increased awareness of personal needs. Malo (1994), in her study with thirty long-term single mothers, examined the "process of exchanges between long-term single mothers and their social network to cope with difficult situations associated with their role" (p. 61). Helping behaviors that were offered most commonly came from friends, rather than from family. And those mothers with a small social network, usually evaluated their support more positively than those mothers with larger networks. This has potential implications for perceptions of daily life when one is able to "share the burdens" with friends or family. Yet if a woman has a very limited network of friends and family, multiple roles may become intrusive and burdening, thus promoting a strong sense about needs for self.

Multiple roles and the strain these roles produce fits in with needs for self and can have dramatic influence over one's emotional and mental state. Napholz (1995) assessed mental health in relation to multiple roles for urbanized American Indian women. What her findings revealed is that those women with highly sex-stereotyped role integration had higher levels of depression, higher role conflict scores, lower self-esteem scores, and lower life satisfaction scores as compared with women who were more androgynous in their personal characteristics.

Pushing Away

Pushing away is a method of responding that allows one to deal with salient aspects of life while putting off other aspects. This is the responding thread that captures how life is navigated on a daily basis. Constantly, decisions are made that reflect priorities, valuing, and perhaps even social and gender expectations. Pushing away can be a means of "leaving for later", and what constitutes later may depend on what else is occurring in a woman's life. Pushing away for some women is a method of responding that has been learned through past life experience and can be linked, at times, with the reality of growing up in an alcoholic home.

> Jody: In order to get back into my school [work], I had to just leave it, leave it for later. I'm used to putting things on hold. I was brought up in an alcoholic family environment, you learn those little things. There were times when you needed your parents and they were drunk, they couldn't support you, and it went to the point where it was every other day, type of thing.

For other women, pushing away may be voiced as procrastination in dealing with body signs that indicate actual health needs. Everyday living may take precedence over addressing these signs.

> Janice: I push health aside when it comes to work and with the kids, and house stuff, you know, family things. And so I tend to, with medications even, I don't take it as much as I am supposed to, I put it back. For the things that I want to do to be healthy, as in exercising, I have put that off for years.

Pushing away may be done consciously or subconsciously. If pushing away is at the conscious level, then there is an awareness of the issue(s), and choice is involved in the act of responding. At other times, pushing away may be more subconscious, and it is not until issues are explored that the method of pushing away emerges through insight.

> Margaret: I kind of avoid dealing with it, I kind of put it aside and keep doing other things so that I'm not pressured by that or thinking about it, or worried about it. Until I'm at the point where I'm in alot of pain, I have to get something done. I think that I do that with alot of different areas in my life.

Summary

Responding as a pattern of meaning has four threads: body responding, taking care, needs for myself, and pushing away. Concepts of the doing of health and weight are incorporated into the taking care meaning thread. The descriptions that explain about responding are not exclusive and separate, rather they are intertwined, and the meaning threads blend so that responding becomes part of a larger whole that is the picture of health.

Surviving

Surviving is the pattern of meaning in the discourse of research participants that exemplifies the persistence, perseverance, and determination in every day life. It is the means through which the participants have been able to deal with life situations, circumstances, and changes that occur. This pattern of meaning reflects the individuality of the participants as each describes different ways of surviving. Surviving is reflected in the words that participants use in sharing about adverse life experiences: building walls, staying in control, fitting in, accepting, and making choices. The following exemplars tell the story of surviving. For Margaret, her means of survival is through embracing change and being adaptable. For Monica, she survives challenging and threatening times by building walls. And for Jody, she survives by creating structure in her busy life through forming daily life routines.

Margaret: *Where do you think that ability to be adaptable comes from?* Uhm. I don't know. I think that I have had to make so many changes in my life, like that I have had to think differently about changing attitudes and changing thoughts and ideas about things, people. I think, different situations have made me learn to be adaptable. You know, when I was married, being, responsibilities that I had to take on there was part of it. Ya, I think that is the way my life has been, changing all the time. You know, when I think back I have been changing myself. Like learning new things, being open to new things, to change. And that's were I find that it works good for me. If I wasn't as adaptable, if I wasn't as open I would not be here. *Where would you be?* I would probably still be married, going through all the business and just accepting it. And, if things would have went on the way they were I would be really bitter, you know, about alot of things. My kids would be different, you know because I would be bitter.

Monica: [*Talking about an experience in her childhood*] And that has really been a catalyst for me in my life, so consequently it has really moulded the way I live my life. Like I have never drunk alcohol in my life, and you know, I have never done drugs or any of that sort of stuff. I guess I think of myself as a being a very, very strong person because I have never wavered from that, ever, ever in my life. You know, it's been something that I am pretty adamant about and have follo[illegible] through on that. So you know, I had some pretty tough rules to follow [illegible]myself. Alot of it was subconscious kinds of things, that I had set for myself and, [pause in speech] I don't know, some of those things have sort of gotten in the way and they come back to haunt me now. But, at the time, I think that it was probably good that I had that happening for myself. *Those were the walls that kept your life together though, right?* Very much so. And my children. My children are, they are just so important to me, you know, they really are. And we have lots of struggles, you know, but I am probably sitting here today largely due to them. Actually during that twenty years there were two times where I attempted suicide, and you know, I think that that has also contributed to who I am today. Just as everything that has happened in my life has. So, you know, that strength that I have and some of the walls and rules that I have set for myself have helped me through some pretty rough times.

Janice: By the time I get home from work, five o'clock, you know, by the time I pick up the kids from the babysitter, and that's only on the days that the kids don't have other activities. And they are in bed, I have them in bed by seven-thirty or eight o'clock. So I kind of follow this schedule, so that it all works like clock-work. *Is that trying to maintain some control over your environment?* Yup [laughter]. *I know it is for me too.* And my husband is always trying to point that out to me, that I go too much on a guideline all the time or by a set of rules for yourself. But then I feel good at the end of the day, I have accomplished all this. The kids are well-fed, and well-rested, well, I don't know about well-fed; that depends on what they're eating. But they have eaten, they've done their homework, they've done their teeth, then whew, I get an hour to myself.

Surviving allows these women to mediate their daily existence. Using past knowledge and understanding of self and others, they are able to persist in a way that is consistent with their self-perceptions. For Margaret, she focusses on the ability to adapt, and recalls over several discussions that being adaptable and receptive to change has opened up many new opportunities, as well as providing her with some challenging circumstances. Being adaptable prompted her to move out of an abusive relationship even when she did not have guaranteed resources to provide for her family's daily needs. Being adaptable allowed Margaret the freedom of movement to become what was dictated through situation or circumstance. Her perseverance in early youth to be as "smart as the top student" afforded her a good education, even though it did not erase the colour of her skin, or stop the name-calling and discrimination. Margaret recognizes that there were certain advantages to being adaptable and flexible. Yet she also recognizes that this means of survival has influenced her perceptions of self. Changing in response to external situations and demands mandated that she often leave behind her Native heritage. She is just now reclaiming her Native-ness as a part of herself, and developing pride in her heritage.

For Monica, she vowed early in her life to avoid alcohol based on her experiences of her childhood. And over the years, additional walls were built that provided the structure, and sometimes protection, for her to persist even when she was not sure that survival was what she wanted. Rules to govern her behavior fostered her own strength of living. Walls and rules were not the only strategies that fostered survival. Spirituality has become an integral part of her life, and this too has strengthened her means of surviving. In effect, a strong sense of spirituality embedded in daily living can be a cornerstone of health, and as such, enable integration of one's inner resources (Stuart, Decko, & Mandle, 1989).

In Jody's case, the structure that she creates in her life allows for a certain degree of smoothness, and control that she is able to place on her environment. Perhaps her survival strategies relates to the unpredictable nature of her relationship with her husband in the early years of their marriage. Establishing structure and routine may be a method to provide stability. Examining Jody's surviving ability causes me to ponder whether her means of surviving reflects larger cultural context and influence. In a study examining Native family management of a common child health problem, Wuest (1991) writes that "the emphasis in native families was more on keeping things running smoothly at home, keeping the child comfortable, and the family functioning" (p. 12). An underlying current in both Jody's case and Wuest's research is that of harmony. Perhaps in her own way, Jody strives to have a harmonious home, and she acts out this desire through establishing structure and routine.

Summary

For each woman, her method of surviving is different. Difference reflects the individuality of personhood, and the historical nature of our beings. Past experiences and situations have shaped these women so that they continue to persist even when they face great adversity. Monica would term this persistence strength, something that is gained through experience and is demonstrated in a continual moving forward using learning and knowledge from past experiences.

Healing

Healing is an internal process and probably different for everyone. Healing is a method of survival for some, and for others it is a way of living, that of being on a healing path. One may correlate a healing path with "being on the Red road" where one lives out her/his existence as a Native person, first and foremost, incorporating cultural practices and spirituality in everyday life (fieldnotes). Others may use the terms of "The Sweetgrass Trail"

to reflect the "spiritual, moral, and philosophical system of guidelines for the natural life progression as established through native religious practices" (Ingram, 1989).

> What is a road or a path? The road is the metaphor for the health of the family of ideas continually investigating themselves to try and find out who they are being in every single moment. Because we are changing constantly, we have to be continually investigating ourselves. Otherwise we lose who we really are. Another meaning for road is the direction or form by which our fears are challenges and the manner in which we have them (Rael, 1993, p. 57).

Learning about healing, for me, began with my first structured volunteer activity at the Centre, that of attending their Healing Week. Time was set aside from routine classroom activities and learning to focus on healing. The Healing Week was aimed primarily at the emotional and spiritual dimensions of self. The activity was controversial in nature; some people did not see how this type of activity fit within an educational context, and for others, healing is seen to be vital to the learning process (fieldnotes). Cognitive aspects of learning are addressed in the day to day classroom and the Healing Week was viewed as an opportunity to integrate the whole learner, through addressing the needs of the learner within a community environment.

As healing is difficult to define, I have complied a composite narrative (Stevens, Hall, & Meleis, 1992) on healing that reflects the combined perspectives of over thirty people. The purpose of the composite narrative is to share a sense of the whole in the description of healing rather than focus on one individual's understanding of the phenomenon. Key phrases were extracted from interviews that I conducted with participants after the Healing Week. These key phrases are then combined into narrative and presented here.

Composite Narrative on Healing

The Healing Week is a way of specifically addressing emotional and spiritual healing, time is set aside for that. A number of strategies, or kinds of healing are planned to span dimensions of the circle. Physical activities such as skiing, walking, and Native dancing can

address the physical dimension. Activities such as breath-work and talking circles address the emotional dimension. Several workshops are planned that incorporate themes of relationships, trust, and insight to address both mental and emotional dimensions. And spiritual activities are planned such as sweats and smudging. Prayer of the elders is also a focal point. It is recognized that there are First Nations ways of healing, and there are other ways. Examples are talking circles for First Nations people, and other means may be relaxation techniques, Thai Chi, and reflexology. Heavy healing is more emotive and delves into often buried emotional issues. Physical health and certain conditions, such as one's mental state can influence healing.

Healing is dealing with issues like learning a better way of living than drinking. It is gaining awareness of the areas that we need to work on, and what obstacles are in one's way. And then what one wants to change is the biggest step. Healing can be seen to have two phases: the first phase is recognizing areas to work on, and the second phase is deciding and implementing an action plan. Looking at sources of pain and exploring issues that have been blocked out are integral. Healing is the blending of the emotional with the cognitive, the bringing up of the emotional to the cognitive.

Setting time aside to work on healing allows one time to examine the past, to look at the traumas of one's life. All people have experienced trauma. And there is a wide variety of issues, like mental abuse, abandonment, and sexual abuse. Sometimes there is anger and rage associated with the traumas and this needs to be released in a safe environment. That is, letting anger out in a good way, not doing this in a bad place or in a bad way.

Healing is personal, you have to want to do it, but people also need to be able to check it out, check out the different ways of working on healing. Everyone has their own ways of dealing with things. Healing is crying but it is also laughing. And people aren't

given more than they can handle at any given point in time. A parallel process is the seeking out of others, of opening up and looking for support. As one becomes more trusting and more insightful into their own issues, they can seek people and resources out to meet their needs, as these can't always be met through personal resources alone. That is where the importance of community, and especially Elders, comes in.

Starting on a healing path means that one accepts that there are no band-aid approaches, and no miracles or quick fixes. It means that at a conscious level people are recognizing that these things have happened and taking some of the skills and some of the pain and moving forward from there. Healing changes people, their relationships, the way they view themselves. For some people, they set unrealistic expectations for themselves, and then have a difficult time dealing with the fact that they may not be able to meet those expectations at that specific time. One needs to recognize that healing is about being able to work on something and feel better about it. And there are no easy solutions.

Health and Healing

Based on my experience at the Healing Week and conducting the evaluation, I was able to integrate this concept into discourse around health. I was specifically interested in the connection between health and healing, because from my perspective, there was much overlap. It is impossible to delineate how much influence my own conceptions of health had on my perspective that health and healing overlap. Yet the overlap of health and healing was validated through participants' interviews in response to me inquiring about linkages between the two concepts. For the research participants, being on a healing path means that decisions and choices are made on an ongoing basis regarding forward movement in life. One participant captures the progression as a moving forward to "one day meeting the Creator."

Another participant blends concepts of forward movement and surviving in her discourse of healing.

> Jody: For me, like, working on healing is working on areas that are bothering me, that's keeping me, that's within me that has to come out in order for me to go on. *Go on to where, the next step?* Go on with life. Cuz I have taken alot of steps up to, like, from where I was, say even ten years ago.

Healing is somewhat an elusive phenomenon to comprehend, and even to articulate. It is a process with no clear end goal and focusses on "being" yet incorporates aspects of action. Individual actions for healing are determined by the needs of the individual. There are not many vocalized shoulds and supposed tos like discourse around the doing of health although there are implicit strategies for healing that are generally sanctioned (fieldnotes). These include talking about feeling, living clean (no drugs or alcohol), taking responsibility for self, and making connections. However, in healing there is a focus on the day to day living, and trying to stay on the healing path. Healing is putting one foot forward, taking one step at a time. If one strays, then sometimes additional strategies are needed to help get back on the path (fieldnotes). Health is viewed as necessary for healing.

> Janice: For me, I feel that there is a connection between health and healing. I feel that if I feel better about myself in the physical and mental parts, that would actually be part of the healing that would take for my mental to be good. They tie in together, I can really relate to the fact that when you're healing and working on all the personal issues that have happened to you, if you need, some of it can be anger and if you release all that anger that is one way of healing. But you still need to be able to let it go, and that can be in walking, exercising, swimming or whatever. I feel that they are connected in that way. And for alot of people, their healing is part of doing healthy things, eating right and exercising.

And healing is necessary for good health. Health and healing are blended concepts that are for some, the same thing. Two main areas of overlap in the concepts come from the recognition of the body-mind self, and health and healing both being based on the circle that represents life (fieldnotes). Having soundness of body-mind self, to some degree, is essential so that

deeper issues in mental and emotional dimensions can be explored and addressed at a personal level.

The dialectic relationship between health and healing is reflected in the literature on the transpersonal perspective. Transpersonal journeying is an attitude and a way of thinking that moves one toward wholeness (Hover-Kramer, 1989). The meanings encapsulated in the words of research participants about health and healing fit with this type of being in the world. In addition, describing the conditions and mechanisms for transpersonal being produces the following guidelines:

> The body needs a balance of rest, exercise, playfulness, and nutrition whereas the emotions must be encouraged to transform, release, and forgive as quickly as possible. Because the mind is such a powerful ally, it is important to clear out negative emotions and take care of the body before working with positive thoughts, called affirmations, to call forth higher consciousness (Hover-Kramer, 1989, p. 31).

What Hover-Kramer has described here is very similar to what research participants have put forward about not only the doing of health, but also about the relationships between health and healing and the movement to a higher understanding of self and others.

Healing in the aforementioned discussion reflects the concept in a process sense. Healing can also incorporate a meaning more aligned with curing or fixing. An example of this is Ingram's (1989) perspective about a medicine man who works to neutralize or deflect a curse, and in doing this, restores balance to the individual. Hultkrantz (1992) also provides many examples of curing by either shamans or medicine men within the rubric of healing. For the most part, in these latter examples, there is discussion about the context of the situation, as well as the connection between spirit-self and physical-self. Jepson (1994) also discusses healing within a context of cure in her recounting of healing practices utilized by Native people of the Pacific Coast. For this group of Native people, their medical system was "a curious blend of two worlds: the supernatural realm of the spirits and sorcery, and the natural

world of healing plants and other natural medicines" (Jepson, 1994, p. 18). The medicine man used the healing powers of plants, leaves, and roots to cure illness and disease. The shaman fit in with the spirit world, and had an active role in healing those that became ill to diagnose, and then depending on this diagnosis, perhaps perform rituals to address supernatural causes, and provide spiritual guidance to the individual.

Summary

Healing and health are intricately connected in the living out of the body-mind self. Healing is critical to self-perceptions of good health, and having soundness of body-mind self is often necessary, but not sufficient, for one to start on a healing path. Like health, healing is individual in its definition and acts of living out healing. If Native concepts of health are being explored, healing as a parallel phenomenon demands equal attention.

Good and Bad Medicine

> To understand the real meaning of the term good medicine, One must first realize the importance of the spiritualism that can be found in everything Natural. It is thus that People living in Nature can make a religion of their daily lives. Good medicine means Positive Spiritual Life. Good medicine means realizing that there is more to Life than meets the eye. Belief in good medicine is one answer to the need that People in Nature find for expressing their humbleness to all that surround them (Wolf, 1990, p. 4).

The concept of medicine emerged through one interview in reference to health strategies and a medicine man. This research participant also brought the point up in discourse on spirituality, and the conflicts that she has encountered in participating in formal religious practices, as well as what she terms "Native spirituality."

> Janice: My great grandmother had also thought that the right type of medicine man could help you with what you were needing help with, whether it was health or what not. But they also stress that there is bad medicine.

In this context, bad medicine is viewed as the medicine that can do harm. Stories about bad medicine get passed on through the generations. Several women have had first hand

experiences of bad medicine that they recounted when I specifically ask about this topic (see Appendix F). Information and details were shared with me, yet I do not believe that this type of data would have emerged without specific questioning.

Good medicine is the medicine that has the ability to counteract the influence of the bad medicine. This is the age old connection between good and evil.

> Janice: My mom believes that bad medicine was put on my great aunt by another lady. She and this one lady had both fallen in love with this one fellow. This other lady went to a medicine person and got some type of medicine to use on my aunt. From there on she always had seizures and fits, like they could find nothing. They knew it was bad medicine.

Bad medicine is done (done to or done on someone) by a bad medicine man. Good medicine men turn into bad medicine men when they do not follow the correct moral and spiritual path (Ingram, 1989). Ingram (1989) explains the good and the bad road in this way:

> The path is extremely difficult to follow and one is constantly tested along the way. If a medicine man abuses access to power by using it in the fulfillment of impulses stemming from greed, jealousy, or selfishness, healing power is irrevocably lost. Thus to be able to access healing power, a medicine man must always resist these temptations. If one does not resist, a point will be reached at which the bad spirits will replace the former assistance of the good spirits. Then there remains little choice but to follow the bad road (p. 76).

Bad medicine may be accomplished through tangible objects (such as the mushroom that Karen found in her bathroom), or through curses placed on someone by a medicine man who practices bad medicine (Jody's recollection of bad medicine and there was not recall about a specific object, just that she felt paralyzed and "wasn't in my body"). Monica goes on to expand the topic of good/bad medicine to intent.

> Monica: I think that when we talk about bad medicine, I mean, there are people out there for heavens sake that talk about putting bad medicine on people to harm them, to hurt them. There are also people that use some of their skills and some of their knowledge in a way that is going to benefit them, and maybe not benefit other people. I see that as being bad medicine.

Given this expanded interpretation, good/bad medicine also is defined or separated through the purpose of the medicine, and whether it is a selfish, or unselfish act. Using the gifts of the self for personal benefit is seen as being bad medicine. For Monica, even making judgements about people is a form of bad medicine because she doesn't think that it's her place to make judgements about other people.

Further understanding of the intent of actions may be fostered through discussing the source of power that accompanies good/bad medicine. Ingram (1989) explores power in his conversations with a Woods Cree medicine man and relates his perspectives on the medicine man's teachings in this manner:

> ...it would seem that there exists separate or parallel systems of good and bad power. Whether there exists separate and mutually exclusive sources of power, or whether the same power is being used for both good and bad purposes is not clear. If all power flows ultimately from the Great Spirit, the notion that there exists separate systems of good and bad power that can be tapped becomes problematic (pp. 71-72).

I wonder about the meaning and symbolism given to certain objects and events and how this relates to an understanding of good/bad medicine. Teaching from grandparents and Elders have filtered down through generations to the women participants, who are immersed in an urban environment. The teachings of their Elders may have included traditional Native views of illness as being of two types: emotional illness due to disharmony with Nature, or bodily illness from a variety of unknown causes. Those unknown causes were thought due to moral transgressions or bad medicine (Kehoe, cited in Cardenas & Lucarz, 1985). How the strains of understanding continue to persist is interesting given our current times where there is development of scientific insights into many previously unexplainable phenomenon. Belief systems have an obvious role here, and how belief systems persist over time. Having a world view that recognizes "one's course in life," somewhat of a deterministic model, may allow for integration of such beliefs about bad medicine.

Whether there is good medicine or bad medicine is not at issue. What is important is that these beliefs exist, and they can very well influence actions within the health domain. I attempted to explore with one participant the decision making process about who to seek help from in relation to her "hallucinations." For Karen, her decision was based on her understanding and expectations of both mainstream health care and medicine men. Both contacts seem to serve different purposes in that she would seek out strategies to deal with the symptoms through her physician, but perhaps the medicine man could address the root cause. From a doctor, she would have sought "something to keep me awake or something to put me out," in other words, strategies to help her deal with symptoms. Yet she never did visit her physician, rather choosing to seek out a medicine man.

Summary

Good/medicine first emerged in one research participant's discourse. I pursued this pattern of meaning with other participants and found that each had very specific and detailed stories to share with me after I put a question forward about good/bad medicine. What this pattern of meaning shows is that beliefs shape meanings given to certain experiences. Having an understanding of such beliefs can provide additional ground for exploration to discover meanings of certain phenomena like health.

Connecting Patterns of Meaning

Meaning-making is ongoing and incorporates elements of time and experience. As a way of exploring meaning-making in relation to health, I undertook an exercise with one of the research participants after I had developed patterns of meaning. At that point in my analysis, I had six patterns of meaning (responding, surviving, healing, well-being, parameters of health, and good/bad medicine), and have since continued with analysis and the patterns have been reduced to four, with the remaining two patterns (well-being and parameters of

health) being incorporated into the analysis of health meaning (Chapter 5). I asked the research participant to sort the (six) patterns of meaning, after reading their definitions, and together we would explore how patterns of meaning may fit into a model of health. Clarification and examples were provided as we went through the definitions. I then asked how the patterns of meaning might fit together. What emerged was a model of health that included our mutual meaning-making as developed through our discourse.

The first action Janice took was to take healing out as an overriding category, or theme that incorporates the other patterns of meaning. Healing, as reviewed earlier, can be conceptualized as working on individual issues and being on the Red Road. It is a process that has no end, and as such, is not a goal-directed activity but rather, a way of living. Yet healing can also be used in reference to "being healed." In this context, healing correlates more with being fixed, or cured. An example may be going to a medicine man about disturbing dreams and the dreams vanishing and with that, the disappearance of the feelings that may be disturbing psychic balance and harmony. Another example is being healed through medicines that cure an ailment such as stomach pain. So along the healing path, there are points in time where one may encounter healing in the latter meaning, that of being healed of what ails you, either through bio-medical means, or Native healing practices (shamanism or medicine man). Both meanings of healing have a theme of "work", either at a personal level in applying healing to the process, or interpersonal on the part of healing in reference to being fixed or cured (the one being fixed and the one doing the fixing). Perhaps this is where the talk about the "work" of personal healing has come from. The term "hard work" was often used in reference to activities that individuals undertook for their own personal healing at the Healing Week (fieldnotes). This connection eluded me until I began exploring how healing is used in daily speech.

From that point, our discussions moved to address the other five patterns of meaning. We began by linking health and healing. Health and healing are blended and connected concepts, one is necessary but not sufficient for the other in a reciprocal and conditional way. So health and healing in its blended form, in this model, is the road that we travel through life. There is ongoing motion as to where an individual is at any given point in time, sometimes being more in the middle of the road, and sometimes being more off to the left side or the right side of the road.

Making a cross-section of the health and healing road, at a given point in time, and extracting it out allows for additional exploration in relation to health meaning and also factors that surround this meaning. So, on closer examination, at any given point in time, individuals make subjective decisions about their well-being. Janice turns this word around to reflect its meaning, that of being well. And individuals can also make subjective decisions that they are not well. The decision about well-being is dependent on the meanings that are pervasive in words such as balance and soundness. How one defines balance provides the structure for subjective decisions around well-being. If balance is seen as an ideal state having the four components of self in harmony, then well-being may also be idealized and therefore seen as unattainable. If balance is seen as working at having some of the four components part of one's life on a weekly basis, then this may be more attainable and provide a better sense of well-being for the individual. Unrealistic expectations about balance may indeed hamper perceptions of well-being.

Meanings ascribed to other aspects of living also shape perceptions of well-being. Parameters of health fit with shaping perceptions of well-being. In effect, one is socialized to what is health and what is not health, and how one applies that at a personal level may incorporate additional elements such as time, responsibilities, values, and beliefs. Good/bad

medicine is a belief about either how medicines are used, or the intent of actions. Bad medicine may cause one to depart from one's healing path for a time, or permanently. Good medicine may prompt one to begin a healing path or foster one to stay on a healing path. Learning about good/bad medicine from parents and grandparents produces some level of awareness of this belief, and whether it is incorporated into one's belief system may be dependent on personal experience.

The complexity of action reflects socialization regarding such issues as parameters of health, responding, surviving, and what it means to have balance in one's life. Janice's stories in past interviews allows me to put these elements together.

> *...if we can use you as an example, what I have termed your surviving is control and structure. That's how you survive, by having this foundation, not in a negative sense or anything. This control is something that allows you to move through time in a way that you see as being productive. Yet that surviving, if we are looking at your focus of surviving as being control, that also reflects back on things like responding when you are taking care and the issue of body weight comes under taking care. And so controlling for you, is also controlling your own body, how you eat and exercise, controlling how you take care of your health through the mediums of exercise and eating. Uhm, and so when I am looking now that I think about it, the issue of control for you is the link between surviving and responding.*

I then ask if Janice can pull through another example, like her medication usage. The following exemplifies a dialectic approach that fosters understanding for both Janice and me.

> I know what my boundaries are when I don't take my medications. *So the consequences of not taking your medications is sickness or illness?* Ya. And for me to, my response to that. I don't know which one comes first then because surviving, for that, my survival skill would kick in *because you want control of your body.* Ya, and I would automatically respond to it by taking my medication. *OK.* I guess that the surviving part would be that I would recognize that my breathing is getting really bad and if I want to go for a walk and I can only walk a block then I better take the medicine. *So being in control in that situation is taking your medicine.* Hum. *But you just don't automatically take them.* No, because if I did [laughter], then I wouldn't push the boundaries of it.

Knowing the boundaries of what health are in relation to her asthma, Janice develops her own way of managing her condition. Perceptions about what "normal" breathing is helps to establish the boundary for what breathing is like when her asthma is really bothering her. Again, perceptions are based on some implicit understanding of what the boundaries are either in relation to health, or something as basic as breathing. How we gain this implicit understanding is through channels of upbringing, ideology, and popular perspectives (socialization).

Dealing with each specific pattern of meaning reinforced that where each fits into a model of health is often dependent on the context and situation at any given point in time. In addition, patterns of meaning are interactional. At times, surviving may be blended with responding and used as a backdrop on which to interpret certain parameters of health. At another time, parameters of health and good/bad medicine may be the cornerstones on which responding is based. And at yet another time, the subjective state of well-being may dictate how healing strategies are utilized. The meanings ascribed to certain activities or beliefs can be motivating or de-motivating for behavior. And meanings evolve over time, through experiencing life.

Summary

The two preceding chapters have provided content to demonstrate the movement through analysis, beginning with sections of actual interview transcript (Appendix E) through developing patterns of meaning. Contexts are given particular attention so that a holistic and realistic representation of the women participants is put forward. The patterns of meaning (responding, surviving, healing, and good/bad medicine) provide context, depth, and richness to understanding the meaning of health for the urban Native women in this study. In the next chapter, I present the final phase of data analysis.

CHAPTER 5: Health Meaning

Health as "how you live your life"

> For the true human, the first thing is to find out how to listen. Listening is different from seeing. Seeing, and the eyes, were created so we could move into things and through things. The ear, on the other hand, was created for the art of giving. One of the attributes of the ear is the give-away; to give into the effort of giving, to give into effort itself, the effort we can find in the toil of work in our lives. When we are listening, we are giving. When we are giving of ourselves, we are strengthening the work-listening-seeing aspect in ourselves. We are listeners to people's cosmic needs. First, we listen to what needs to be done, then we use our eyes to see what needs to be done. But if we start with trying to see what needs to be done we will miss the point and we will not really touch the basic humanity of the situation that is talking to us at that moment in time. So it is important to be sensitive to what qualities the ear brings, and what qualities effort brings (Rael & Marlow, 1993, p. 70).

Health meaning is presented here as a form of theoretical understanding. As the meanings derived from the data are based on talk, the analysis is inherently limited as there was not an opportunity to observe how talk was consistent or inconsistent with action. Yet for the purposes of this study, I have argued earlier that I employed a perspective congruent with that of cognitive anthropologists so that through language, valid meanings can be derived.

With this (final) phase of analysis, I extracted data segments to answer the question "what does health mean?" Over ninety data segments were gleaned from the health-related data. From the data segments, categories and themes were developed. The categories reflect the essence of the data segment, and the themes are inclusive of several categories. The themes were then viewed together to capture a holistic interpretation of health meaning as put forward through the language of the research participants. In effect, this phase of analysis was "dividing [health] into its constituent parts, then identifying the relationship among the parts, and their relationship to the whole" (Spradley, 1979, p. 92). Four themes have been developed through analysis. These are: the body, actions, feelings, and visioning. Between and among the themes there is overlap, and as such, the themes are not exclusive. The themes can be

integrated to an interpretation of health meaning as "who you are" and "what you do." *Who you are* captures the core of the individual both in isolation and in interaction with others, and is a means of presenting the self. *What you do* reflects the movement and fluidity of the self demonstrated through thoughts and actions. Including the dimension of time, in my perspective a constant reality that creates our historical selves, who you are and what you do merge to become "how you live your life." The word live reflects a vibrant, persistent being in the world, and the word how encompasses elements of time, change, and process.

Each of the themes will be presented; research participants' narratives and exemplars are included to demonstrate depth as well as how the categories are grounded in the research data. What emerges is a description of health meaning that is based in multivocalism. Using a metaphor of painting a picture of health, the themes can be viewed as the primary colours used to paint main elements in a picture that is entitled "*How you live your life*."

The body as a parameter of health

The body theme is inclusive of many categories based in the physical self and the presencing of the physical self in daily life. For the women involved in this study, the body theme encompasses categories of weight, exercise, rest, energy, and strength.

Weight is central to the lives of several of the women, and as such, demonstrates the physical presencing of the self in a bodily form. How a woman interprets her weight is based on self-ideas and perceptions of others that may then become internalized into self-ideas. An ideal of weight is used as the background upon which to compare self-weight and the weight of others. Fitting into what is perceived as the ideal weight is an indicator of health.

> Margaret: I picture my kids as being healthy as they are not overweight, they are not underweight, they are the right size for their weight.

Linked with weight is the permeance of food. Food is categorized as either right or wrong foods, yet for some, there is a belief that it is what is right for you, reflecting individuality as

well as value judgements about food and food consumption. Right foods include such things as fruit, vegetables, and milk.

Exercising is also correlated with health. Often in the words of the research participants "eating right and exercising" are what emerged as first thoughts when asked what health means to them. Exercising is one aspect of the doing of the body that in turn becomes integrated into self-ideas and becomes part of one's subjective judgements about health.

> Janice: I know that my asthma wouldn't bother me as much if I were exercising. I don't exercise as much I would like to. I feel that if I was able to do more for myself, exercise more, I would feel better.

Necessary body functions like rest are also part of the body theme that signifies health. Not having adequate rest is viewed as a health problem. Rest is the time of recuperation that allows one to regain strength and energy, as well as subconsciously process daily events. Rest is integrated with exercise and physical presencing as rest is necessary to have the bodily ability to exercise.

> Karen: I haven't been getting proper rest lately. Physically that drains you, emotionally you're gong to have some type of discomfort like being tired all the time. And you're less likely to want to do anything too strenuous because you're already too tired. Like even going for a walk is like a big effort.

The body theme also includes energy and strength. Energy may be a prerequisite for exercise, and a result of rest. Energy is the presencing of the self and is captured in words such as "having energy", and "being energetic." Jody typifies this category of energy in her statement: "An active energetic person is what I see health is." Margaret echoes this sentiment.

> Margaret: They [children] are not lacking alot of energy, they've got enough energy. More than enough sometimes [laughter].

Strength reflects resistance of the body to insults such as disease or sickness. In speaking of her children, Margaret extends her interpretation that they are healthy because of enough

energy to include the fact that "they're not sick all the time...don't catch colds easy...and haven't had any major illness." The category of strength also resonates an issue of control. Strength can be control over one's body so that it does not manifest in disease or sickness (read: vulnerability). In this case, there is a separation of the physical self from other components of self so that one can "master" the body and it's physical vulnerability.

> Monica: I have never felt comfortable being sick. To me, sick is helpless and useless and I couldn't allow myself to be that. I had to be there for the kids, and I had to be the support and the wage earner. I couldn't be sick because it took time and I just didn't have that. So, I guess I just pushed stuff back, and it worked, I think, to a certain degree although it manifest itself, like I said, in the eating behavior. [*And she goes on to say*] When I was in my situation with health and disease, I felt that my body was the only thing that I had control of, and that by having control I was saying, "I'm not going to get sick, and this isn't going to happen." There was alot of stuff happening in there, but I wasn't letting it happen visually and all that kind of stuff. So I really do feel that we have alot of control, like our minds have alot of control over our bodies and how our bodies are going to respond and react to different situations.

The issue of control versus vulnerability is laden with complex meanings as show through Monica's narrative.

Actions as a parameter of health

Certain actions are used to describe health meaning. Exercise has been addressed under the body theme, yet it also could be placed under the action theme. Exercise is an example showing that categories merge, and thus so do themes, rather than being exclusive and isolated. Other actions include activity, attending, and talking.

Activity is the actions that individuals perform either through choice or necessity as part of daily living. One woman puts this succinctly: "That is what I think health is, being able to do activities and stuff." Health to another women is exemplified in the phrase being able "to do things." These things include such activities as going on the bus, and getting out to the store. For several research participants, health is talked about in relation to role function

and performance. One is unhealthy when routine activities cannot be performed, such as going to work, doing housework, or caring for children. In Janice's narratives, she explains about health meaning through using her mother to illustrate.

> Janice: She's not as healthy as she could be. She's let herself go so much. And I notice in the things that she does too. She barely, she will eat maybe once or twice a day. You car see it in her house too, she doesn't look after it as much. And looking at her now, she can't do too much. I just don't see her "in health" in the physical sense. Mentally, certainly she is still fine.

In this exemplar, Janice seems to expect some usual level of activity, and when her mother does not display these expected behaviours, then she is not seen as being as healthy as she could be.

Activities demonstrate the functional components of health in a physical sense, and also in a cognitive sense. Talking reflects the cognitive action of health that allows for catharsis, exploration, problem solving, and setting action plans. Janice states: "It's being able to talk about your feelings. Not holding it inside, but talking about it." She goes on to say that she attends counselling and a woman's group to help her with this talking, as a way of helping her deal with her feelings and emotions.

> Janice: I know from my past that I always was the person who kept everything inside. If someone bothered me or irritated me, I would never do anything about it. I would just keep it all locked up, hold it all in. And with the counselling and the women's group, I am able to look at the situation, what happened, and see what, it wasn't just me or whatever, and how to deal with it in an appropriate way. And then I feel better if it's released from me, so I don't have the burden or stress of that situation on me.

And for Monica talking encompasses several feelings.

> Monica: And talking about them [health issues] and not feeling bad or embarrassed or ashamed or guilty, or any of that type of stuff.

Attending is also addressed through the discourse of the research participants on the topic of health meaning. By attending, I am referring to the actions of paying attention to or addressing specific areas of self through such common strategies as eating properly and getting

adequate rest, but also such actions as protecting self by not taking responsibility for others.

> Monica: It's too easy to slip back into that, it's too easy to start internalizing things, and it's too easy to start taking care of things and taking responsibility for people's behavior.

> Jody: [Health is] how they take care of themselves, how they eat, their physical.

> Margaret: When I worry, I don't look after myself properly because I go farther than I should. I stay up late, and I don't eat right, not looking after myself.

Triggers for attending are often physical signs, such as fatigue, pain, or sickness, that indicate one has not been attending to certain aspects of the self. Knowing at an internal level what the self needs also directs the category of attending. Internal knowing is knowing that has become integrated into self understanding based on past experiences. Monica provides an example of internal knowing in consciously working at not assuming responsibility for everything and everyone. This action entails giving up some responsibility for situations and people, and narrowing one's personal focus to attending to one's self and perceived needs.

Feelings as a parameter of health

Feelings predominate data segments on health meaning as told through language such as "feeling good", "well-being", and "happiness." Feelings encompasses subjective, affective experiences of the self. At times, feelings are based on interactions with others, and at other times are based primarily on internal reflections. Internal reflections, or self-perceptions, are common in describing health meaning. Such phrases as "feeling good about yourself" and "having self-esteem" are examples of self-perceptions. Self-perceptions involve some type of analysis at the personal level that prompts one to form opinions about one's subjective being in terms of feelings.

> Monica: If I still felt safe and I still felt accepted and I still felt loved, I would still feel healthy. Because to me, that's the most important thing in my life, is to feel safe and accepted.

Feelings are also the sensing of the body-mind self, that are verbalized in feeling well/good and not feeling well.

> Janice: I can look at health and say that it means eating right and getting exercise, you know, feeling good about yourself. Like maybe I am overweight of whatever, it's how I feel about myself. And your physical, going along with it, is your health. I don't feel all that good about myself health-wise. I feel that if I was able to do more for myself, exercise more, I would feel better. So that's why I think that I don't feel so good about myself.

The following interaction demonstrates the language used around "feeling" to differentiate healthy and unhealthy.

> Jody: Unhealthy means not feeling well. If you are not healthy then you are sick or unhealthy. *And how you feel is health?* Ya. *So not feeling right is unhealthy?* Ya. I am in a very unhealthy relationship. *So there's more to health than physical?* Ya, it's how your mind works too.

And Monica explains how body-mind can be dichotomized in relation to perceived health, that is, the subjective decision that one is healthy or not healthy.

> Monica: For me, there are lots of times when I am sick and disease-free, but I still don't feel like I'm in really good health because mentally and emotionally I am not feeling that way. So, to me that says that I'm not. So again, but sometimes I might be, it just depends on where I'm at at that particular time.

Feeling well and not feeling well can be inclusive of body-mind, or can separate out body and mind. In the latter case, one can feel well physically but emotionally one may have issues. If this is the case, then others may evaluate the individual as healthy, based on their physical presencing, yet the individual would view themselves as not healthy. It is through the separation of body-mind that contradictions can occur between one's own judgements about health and how others judge that individual's health.

The feeling theme also includes categories of happiness and well-being. Happiness is equated with health by several women. Margaret uses health and happiness interchangeably in her comment that "it's obvious that what goes on with them [children] is part of my happiness, my health." Happiness is inclusive of such dimensions as joy and pleasure.

Well-being

When participants were asked about the meaning of health, a frequently used word was well-being. Well-being has many dimensions and is somewhat of an all-inclusive term that reflects a certain level of soundness about self (body and mind). Spirituality also juxtaposes with well-being in that research participants view spirituality as another component of self, and therefore is integral to one's subjectivity. For Monica, she separates well-being into body and mind through words of "physical well-being" and "personal well-being." It is the personal well-being that equates with the affective, emotional components of self. Personal well-being is inclusive of such elements as self-esteem, self worth, and self-value.

> Monica: Speaks to me a large part in being healthy, you know, my personal well-being. Because during the time that I was in that abusive relationship I didn't have any physical health issues, you know, like I was fairly healthy. But in terms of my well-being, I was not healthy at all. But now, I almost feel like it's completely reversed, the situation. That I'm not in that relationship anymore and my well-being, I feel pretty stable emotionally, mentally, and physically, and most important, spiritually. That has really helped me. But my physical health had really been impacted by the relationship, and I know that it had a large part to do with some of the health issues that I have now.

At the core of well-being is the concept of balance. One participant frames the concept of balance in terms of a feeling of peace, yet another explains balance through using the metaphor of an ecosystem; "if one thing is out of balance, then it's all out of balance." Another participant talks of the struggle that she has trying to maintain a sense of balance in her life.

> Jody: I have to make time [to work on healing]. Sometimes I forget about it, some areas, I go days sometimes, I have a hard time really balancing everything in my life out. I think that's why I get into that dangerous zone.

For Jody, the dangerous zone is when she separates her emotions from what is occurring in her day to day life. This action is a protective one when she is feeling overwhelmed, and can

lead to "maybe a breakdown, when you don't care. You shut everything down. You don't deal with anything, it just piles up."

For Monica, well-being is vocalized in an accepting of chronic health issues, and a meshing of her emotional and physical well-being. Through the avenue of accepting, a sense of balance is formed that integrates her relationships and environments into a holistic understanding. Feelings of safety, feeling good about herself, and feeling loved in an unconditional way allow for the meshing of emotional and physical well-being.

> Monica: You know, like I have seen, it has been my experience that there's emotional well-being and there's this [physical well-being], and for me they have kind of come together and they are meshing. Because you know, I feel safe and I feel loved, and you know, I have health issues and I'm dealing with them because that was the other thing, that I was scared to be sick. My husband said you know, it's OK, you are sick and that's alright and what we need to do is deal with that, look at those things, find out how we can work our way through that and get you on the road to being better. So now my emotional well-being and my health, my physical well-being are like this [joins and interlocks fingers] rather than being separate.

Balance, in the words of the women participants, usually involves the four dimensions of self, or what is viewed as the four components of the medicine wheel: physical, mental, emotional, and spiritual. Rael & Marlow (1993) describe the medicine wheel as having corridors in the four directions and a centre (east = mental, south = emotional, west = physical, north = spiritual, and Centre = heart), each representing the "essence of consciousness."

> Janice: [When asked how she defines balance in relation to health] I guess, if you are talking about the four dimensions of emotional, spiritual, physical, and mental, then balance would be having each one of those, something out of each one of those things part of my life.

The medicine wheel concept is integrated into the lives of the participants through the teachings of the facilitators at the Learning Centre. The physical dimension is the body-self, and in talking about health, the physical dimension reflects in the women's talk about disease,

illness, sickness, and being unhealthy. Colds, asthma, weight, and stomach problems emerge in conversation about physical body-selves. Mental self is that which correlates with the intellect, or the mind. Emotional is the feelings from the heart, the affective dimension of self. Spiritual is a person's belief system, and often equates with connecting with a higher power. For some, spirituality may be manifest in religious practices.

> Do you think your religion is right? Does it make you happy? Does it keep you from trespassing against others? Yes? Then, brother or sister, you have found the right religion for you! What difference is it to me how your religion balances out on the scale of mine? If it doesn't belong on there, then I won't put it on there-then it wouldn't affect the balance of mine, eh? Now, if you will accept all that, then there won't even be a beginning for an argument about our methods of prayer - we'll just say to each other: "Yours is good...Yours is good." And what if you don't accept my suggestion of "what is good for you and doesn't hurt me is good?" Well, I'll show you my garden; give you a sample of the harvest; hope I've inspired you; and let you go back to survey the extent of your own weed patch. If you still like it, then that's good, too. Just give me a little respect... (Wolf, 1990, p. 60).

The spiritual dimension of self is also manifest in cultural practices like smudging, sweats, and being with Mother Nature.

For Monica, balance is equal valuing of the four dimensions of self, and negotiating times when a certain dimension will "be at the forefront." Through experience and conscious work, Monica feels that the times when one dimension "takes over" are not as frequent. She narrates an experience she had not long ago that involved her ex-husband.

> Monica: Like when I had that scare, for about five hours my first instinct was to run and hide. And it lasted about five hours and then I went, "no, this isn't going to happen" and that old, you know, this is not going to happen to me, I know what is happening here and I recognized what I was doing and I was able to come back and balance again. And not just let the emotions take control of me, and so, I think that's with my health also, you know, I'm not just letting the physical take control of me. I know that for my health now that I need, it's my physical, my mental, my spiritual, and my emotional, it's all balanced.

Karen succinctly summarizes what health means to her by relating that "you take everything that's happening in your life and you find a happy medium, the balance between your physical,

mental and emotional, and spiritual."

Balance is in continual motion. It is the summation of a dynamic and flexible relationship with contextual variables and lived experiences. From the women participant's discourse, there are degrees or shades of balance. Subjective judgements lead to an evaluative conclusion about how balanced one is.

> Karen: *What happens when the four components aren't in balance?* It kind of throws every other part of your life our of balance, it seems like something flips over. Right now I find it really hard for myself to get back in balance. Nothing, because of all my emotional needs in myself, I find it hard to deal with, and it makes it hard to balance it [tearful].

For Margaret, her understanding of balance is inclusive of her family, thus underscoring the importance of her mothering role.

> Margaret: I know what I have to do at home, the main things, I get it done, like the housework, I feed my kids, I do all that I have to do at home. But I need something for myself. What I want to do, like get out and do things, that's what I've been missing, and that's why I am off balance I think. I've been out of balance because I haven't been able to do the things that I want even with my family.

Doing things with her family is constrained by her daily reality of insufficient finances. So for Margaret, balance includes the social and contextual factors that construct her life, sometimes without much choice on her part.

In summary, well-being is the soundness of the body-mind self as negotiated through concepts of balance and subjective judgements about body-mind sensing (feeling well or good/not feeling well). That is, well-being envelops feelings and balance. Well-being is eclectic in nature, reflecting the individuality of the women participants.

The theme of feelings reflect the relationships with self and others emerging as affective judgements about the self, such as statements about feelings and well-being. As humans we are interactional beings. And based on our capacity for interaction, much of our self definitions, perceptions, and ideas are formed through interaction with other people. As

such, health meanings mirrors this interdependency of thought, as formed through relationships, either self-relationships, or relationships with other people. Jody provides a glimpse of this insight in describing her relationship as unhealthy because of unequal power relationships, over-possessiveness, and abuse.

Visioning as a parameter of health

Visioning encompasses the plans, goals, and directions of an individual along one's life pathway. Visioning correlates with the cognitive aspect of self, but has strong connections with feelings and actions, and in some ways, with the body theme. In the latter case, visioning may be linked with ideals and goals set regarding weight, food intake, or exercising.

> Janice: Within that sense [health], people get doing things for themselves, other people have to do other things. And I feel that for me to feel healthy, healthier about myself, I have to know what has to be done for me. No one can tell me "you have to do that." You know? I've got to know, like with my weight.

The theme of visioning does not seem to have an end, rather it is a continuum over time with new goals and directions being set based on life experiences and interpretations of these experiences.

> Margaret: I'm stretching myself too much and I'm not getting what I want, that self-satisfaction that I want, you know, so maybe it's time that I sat down and rearranged my thinking a little bit in terms of what I want and what I'm looking for.

In the above exemplar, Margaret captures the essence of visioning as occurring over time, and its meanings of goals and directions. Visioning provides structure and purpose to daily life as well as establishing a course for the future.

For Karen, she links visioning with a sense of being self-aware, and these characteristics afford the opportunity for making choices and decisions more obvious because "you know what you want, and how you want things to be." Again, visioning is the charting of the present and the future through a process of setting goals.

How you live your life

How you live your life summarizes the themes that emerged in women's talk about health meaning. Life is represented by the circle, and includes four dimension of self. These four dimensions of self are often recounted in discussion about health meaning. The self can be conceptualized as four overlapping and integrative dimensions: physical, mental, emotional, and spiritual. The themes discussed above resonate the four dimensions of self in two ways. The first way is that by taking an example from the body theme, connections can be made to the four dimensions of self. Using the example of Karen talking about inadequate rest, there are strong connections between rest and physical self, rest and mental self, rest and emotional self, and potentially even spiritual self as she does not have the energy for walking. Depending on what activities are the medium for spirituality, inadequate rest may influence her spiritual self. The second way that the themes are connected with the four dimensions of self is that each theme roughly mirrors one dimension of self. The body theme is reflective of the physical dimension, the feelings theme is reflective of the emotional dimension, some actions can be linked with the mental dimension (e.g., talking), and visioning reflects the spiritual dimension.

The presented themes all have normative characteristic about them. Like in Karen's exemplar about rest, she relates that there is a "proper" amount of rest. Normative characteristics are integrated into the self and become part of the structure through which judgements and conclusions are made about health. What is unclear, and was not explored in the interviews to a large extent, is how these normative characteristics are integrated into the self. However, one research participant determined that socialization through advertising plays a large role in her learning about social prescriptions and normative expectations.

The normative characteristics imply an ideal. Thus, an ideal, or ideals, are used as a constant source for self-comparison. In other words, the themes are parameters that address the concept of health meaning. The above recounted themes are indicators of how one is doing in the living of one's life. Using action as an indicator or parameter of health tells one about the capacity for action as well as how one is implementing such actions as talking about feelings, or eating the right foods.

To summarize up to this point, underlying the discourse of health is the foundation of an ideal, perhaps some striving for perfection that emerges from a historical Christian view of wanting to be perfect in the eyes of God. Ideal(s) have become integrated into the lives of the women in this study; they have each created some ideal-self that is the referent for comparison and judgement about health. And there is an implicit goal that action should be taken to move one toward that ideal-self. Along with the ideal-self is the shadow-self. The shadow-self is that which as individuals we try and avoid. Shadow-self is often in opposition with the ideal-self. One works at emulating the ideal-self whereas one works at not emulating the shadow-self. For these women, components of their shadow-selves may indeed emerge from negative stereotypes about Native people, or about past life situations that they have now moved beyond (such as alcoholism or abusive relationships). The ideal-self and the shadow-self both push the individual towards seeking the ideal-self that has become internalized. The themes of the body, actions, feelings, and visioning, provide structure to the idealized self, and as such, become parameters upon which personal judgements are made about one's health.

Health, as told through the talk of the research participants, can be viewed as multidimensional and holistic, interconnected with the self, and inseparable from daily living. It is this connection with daily living that articulates health as a process and the salience of parameters reflect health as a state with dynamic attributes. Health is shaped through the

shadow-self and the ideal-self. Using these two aspects of self-perception as referents, judgements about health are dynamic and dependent on context, situations, and experiences.

> Monica: I can't describe what health is and what healing is because it means different things to me at different times. Health and disease are challenging definitions I think because what one person sees as sick, another person doesn't. I think that it depends on the person.

Because health judgements are individual and dynamic, the contexts, experiences, and situations that dictate judgements require attention and explication. One's subjective understanding of health (at any given time) can be influenced by a number of situations and experiences. In the following chapter, I provide the contexts around health as how you live your life that has been described above. The contexts are gleaned from discourse around health meaning, and demonstrate the complexity of thoughts for the women involved with the research process.

Summary

Examining health meanings, as told through discourse on the topic of health, has revealed four themes: the body, actions, feelings, and visioning. These themes are used as reference points for subjective judgments about one's health based on the ideal-self and the shadow-self. Through the exploration of health themes in combination with patterns of meaning and lived experience, an integrated conceptualization of health emerges, that of *how you live your life*. Health perceptions evolve based on experiences, new beliefs, and changing perceptions and ideas. Perceptions are not stagnant, and perception becomes the grounding point for health conceptions. Over time, perception is channelled through the parameters of the body, actions, feelings, and visioning, and judgements about health are produced. These judgements are then fed back into the self through an intermediating layer of thoughts and actions. New perceptions are formed, and the process recycles. How one perceives what is meaningful or salient addresses the inherent individuality of our humanness.

CHAPTER 6: Conclusions

In this research, my intent is to present a picture of health meaning through analyzing the words of Native women who reside in an urban area. In addition, a process emerges out of the picture of health. I have developed this process into a model of health thinking that integrates health meaning and daily context. I struggle with how best to present the picture that the research participants and I jointly construct, and my perspectives on the data that I have collected. Much is left to the reader to form judgements and perhaps reach independent conclusions about both the data, and the method of presentation. My aim, through using ethnographic strategies, is to come to some level of understanding about health from people of a race and heritage other than my own, with perhaps different cultural values, and often living a reality other than my own, and present that perspective. There is no coherent manner in which to separate out which health themes or patterns of meaning are related to the research participants being Native, or being women, or being in lower social economic strata, or having abuse issues in their past or present. What is revealed in the presentation of data excerpts and analysis is the phenomenological world of the participants.

My role in the writing is to reconstruct and represent the realities put forward by the women, in effect, produce a third interpretive reality (Agar, 1986). These women narrate life events, experiences, and personal perceptions, and this becomes the foundation on which insight and understanding is gained. At one level is the picture of health, and at a second level, using those meanings, a model of health thinking has been formulated. Data are collected through the world view of the research participants (as represented and understood in their talk) and then screened through the researcher's filters, such as assumptions and methods (Parse, Coyne, & Smith, 1985). There are no absolutes using ethnographic strategies. Yet in

the telling of what has transpired over the last year, readers may themselves gain additional understanding and thus expand their box as I have expanded mine. The box of personal knowing can harshly inhibit authentic interactions with people based on such social categories as race, class, and gender. Expanding the box causes one to challenge many previously held assumptions, modes of interactions, ways of communicating, the researcher-participant relationship, and even how research questions evolve.

For me, confronting these challenges has transformed me in many ways. One critical transformation has been an increased commitment to a world view that is inclusive of multiple realities. If this were not the case, I believe that this question of research would have been difficult, if not impossible, to pursue. Attending to the individuality of the research participants also reflects my world view that accepts multiple realities.

However, there is comfort in knowing some commonality exists among people. Taking a perspective of multiple realities to the extreme would negate nurses ever working with clients, rather each would be functioning in her/his own perspective with possibly no overlap in shared meanings. I therefore take the position that there is some degree of shared reality that can be communicated and comprehended within a perspective of multiple realities. Commonalities, or what I have termed health themes and patterns of meaning, are apparent in this research on health meaning. This commonality can be used as a foundation on which to dialogue with clients, to work together in the small area of overlap that can be thought of as shared meaning. Yet exploring shared meaning entails communications that are accepting and not power-dominated by the health care professional (Hewison, 1995; Jarrett & Payne, 1995). Putting each urban Native woman a nurse encounters within the confines of what is presented here however would be unethical and unprofessional. And grouping all urban Native women as homogeneous due to their sex and gender is also not fitting, as this action may assume an

ahistorical, universal unity that is not present (Mohanty, 1991). "In reality, we [women] are a mixed lot, our gender role and options shaped by history, culture, and deep divisions across class and color lines" (Kreiger & Fee, 1994). The health themes and patterns of meanings are not recipe-card like. Each woman is an individual first and foremost, and she carries her own repertoire of skills, experiences, and thoughts that foster her persistence, and growth in this world.

Explicating Health Meaning

For the women who participated in this research, health is conceptualized as a multidimensional and complex process, that of "how you live your life." How you live your life is based on internalized ideal-self and shadow-self that are constant points of comparison for subjective judgements about perceived health. Health is not talked about as a static state or a goal that is inherently achievable. Terming health as a process includes the temporality and the fluidity of health judgements. Through a process, life is navigated on a day to day basis incorporating past knowledge, experience, and understanding into how the living process is expressed and manifest. Each woman has had different experiences, and different critical incidents that have been incorporated into her psyche (ideal-self and shadow-self) and thus play a role in personal, cognitive explanations. These cognitive explanations presumably become motivators or deterrents for certain behavior (e.g., action or non-action for health). Discourse around health conceptions reflects a dynamic dialectic with the actual perception of health changing in response to such things as body signs, sense of well-being, and surviving. Patterns of meaning give shape to how health is lived, that is, how health is manifest in daily living. As well, the identified patterns of meaning are mediating layers through which health is given additional meaning and interpretation at an individual level. In effect, health is how one lives one's life as shown through talk of who one is and what one does.

Blended into the meaning of health is the concept of balance. Navigation rests on balance, yet balance could be visualized as the tacking back and forth of a sailboat on a given navigational path. That given path, as dictated by certain coordinates, allows for some degree of maneuvering and variation within a given range. The given range of movement equates with the parameters of health as established by the ideal-self, shadow-self, experience, testing one's limits in physical, emotional, spiritual, and mental realms, and prevalent ideology.

Healing is also blended with the concept of health for the women in this study. Both health and healing are inclusive and holistic in their conceptions, with attention being paid to the four dimensions of self. Healing reflects dimensions of time and work, as does health. Healing is necessary, but not sufficient for health; and health is necessary but not sufficient for healing. Thus a contingent and reciprocal relationship is forged between the two concepts.

Based on aforementioned meanings, health is manifest through the living of life. What is apparent is that life experience contributes to more eclectic and encompassing self-understandings of health. This discovery is accentuated by one research participant who has, thus far, not been included in this document's examples or exemplars. I think of Peggy as someone that provided additional validation to the discovery that personal understanding of health meaning expands over time. Peggy's talk about health was quite similar to the other voices presented thus far. She viewed herself as healthy due to talking about her feelings, exercising, and eating right (what was right for her). What was absent in Peggy's talk was the complexity of everyday life that the other women mixed in with their discourse on health. Her life vignette is found in Appendix G. Peggy's voice lends points of comparison and affirmation to the voices of the other research participants.

Through the course of interviewing, it became apparent that life is inseparable from health. This insight emerged from the beginning interviews when I began with asking about

health meaning. How women responded was in terms of simple definitions about health; as something that wasn't happening in the present. Morse (1992b) explains that the situation I encountered is related to researching "socially constructed concepts [which] may have little relationship with reality" (p. 5). Changing strategies in interviewing fostered the sharing of stories about living and life, about individual perceptions of well-being. And in these tellings, discourse around parameters or indicators, contexts, and mediating influences were shared. Health meanings moved from being socially sanctioned definitions into the lived world of the research participants. Life (through the living) provides structures and contexts for how health is both perceived at a personal level and conceptualized at a cognitive level. Meanings of health are thus inclusive of the diversity of individual experience and how these experiences shape meanings. Meanings are formed in context (Hinds, Chaves, Cypress, 1992; Mishler, 1979). How one gives meaning to a phenomenon like health is dependent on the lenses, or contexts, that are incorporated into the self.

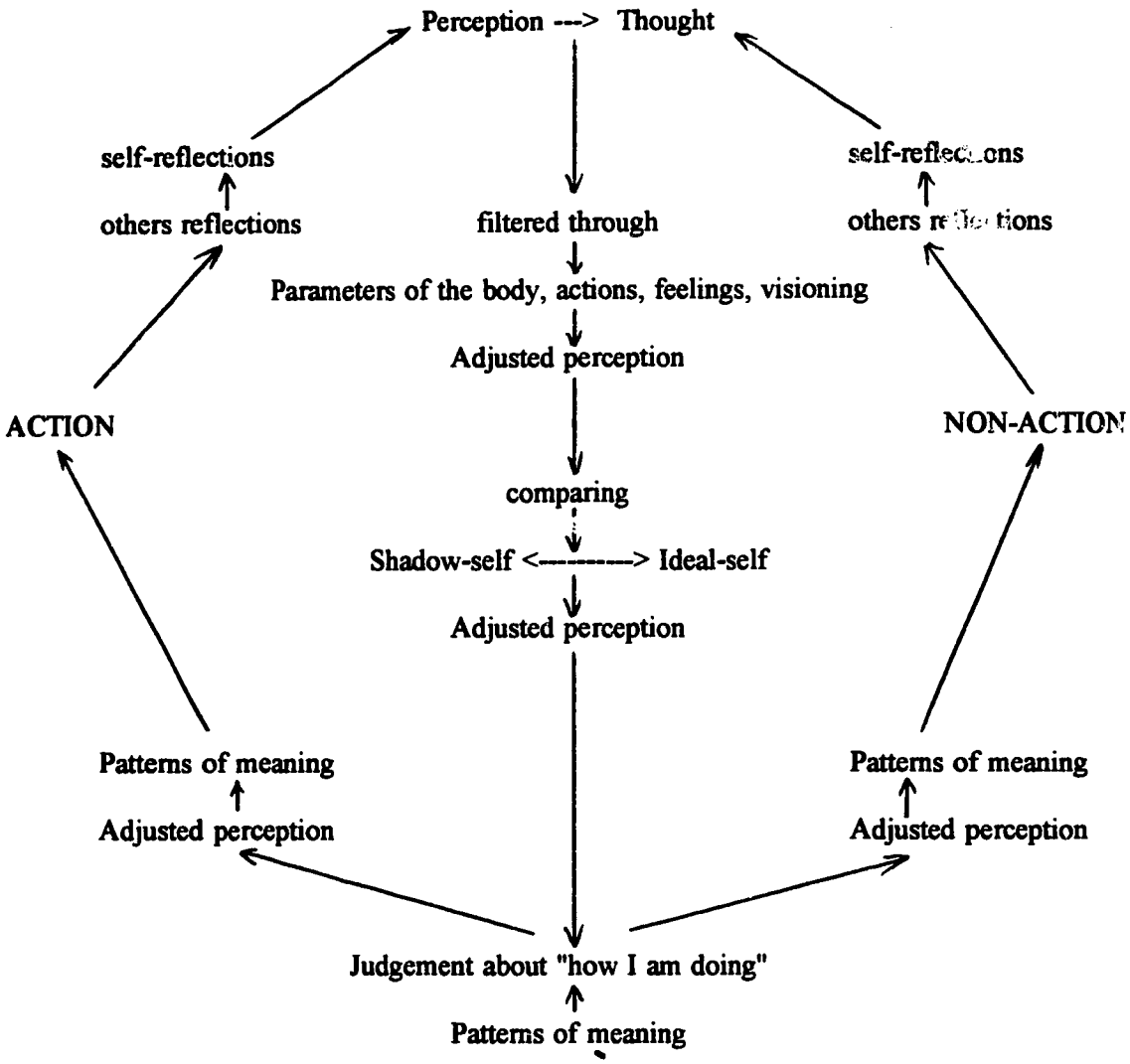
Thinking About Health

Thought about health is the goal of the inquiry that is the subject of this thesis. The creation of these thoughts about health is a cognitive process. Therefore, it can be argued that narratives of women are constructed from their perceptions, recollections, and experiences, and can be seen as containing theoretical expressions within them. These theoretical expressions are derived from descriptions of health meanings found in the narratives. It is notable that unlike academic theorizing, the theorizing of the women in the study is contextualized in their lives. Therefore, in order to understand the theoretical expressions of the participating women, the contexts of their lives must be understood as well as the meaning of the relationship between context and theory has for them. It is for these aforementioned reasons that the contexts in which thought about health is created, mediated, facilitated, constrained, and

sometimes transformed, has been included in this work.

In the process of understanding the relationship between health meaning and the contexts in which the women live, evidence of processes by which the women in the study think about their own health have emerged. From the interview data I have developed a model[11] that shows the processes used to think about health. I have called those processes "health thinking"; that is, how the central concepts of health meaning (as outlined above) and the multiple context of everyday living (Chapter three and four) work together to form the complex of thought-action-living. Part of the understandings that ground this model are the discussions presented earlier on connecting patterns of meaning which were co-developed between myself and one of the research participants. This is an important point, in that in using central ideas from that discussion with a research participant, validity is given to the model of health thinking. The model on health thinking captures the way that the research participants think about their health (as evidence through their talk), and conduct decision-making in order to produce deliberate action (or non-action). The model is presented below.

Health thinking model



Elements of the health thinking model

The visual model presented above has several key concepts which require explanation. Basically there are two types of concepts in the model: images and activities. Images are the mental pictures that individuals form through their own self-reflections and through others reflecting images back to them. Examples of image concepts in the model are the outlined parameters of health, as well as the ideal-self and shadow-self. Activities are the actions that can transform perceptions and thoughts, or give additional meaning to thought. Examples of activities in the model are filtering through and judgements.

The main elements of the model are: perception, filtering through, parameters of health, shadow-self and ideal-self, judgements, patterns of meaning, and self-reflections and reflections of others. Perception is the basic mental representation of information gained through the senses. How a perception is given meaning within the individual translates into a thought. "Filtering through" means that thought passes through past knowledge, ideology, and learned expectations, and in the passing through, certain elements may be removed or transformed. Parameters of health refer to the indicators of health. For the women involved with this study, four parameters of health emerged in their talk: parameters of the body, actions, feelings, and visioning. Shadow-self is the aspect of self that one works to avoid, the parts of the self that reflect the negative aspects of one's life, or certain negative stereotypes associated with given social labels. The ideal-self is the self that one works to emulate. Both the ideal-self (through emulating) and the shadow-self (through avoiding) are used to move the individual toward the ideal-self. Judgements are subjective decisions or conclusions that involve certain deliberations, examinations, and considerations. Patterns of meaning include such things as beliefs (e.g., good or bad medicine) and daily reality (e.g., surviving and responding) and reflect the complexity of life. Patterns of meaning often provide context for

thought and action. Self-reflections and reflections of others are formed through analysis of an action or non-action in relation to health. Reflections on actions may be how one views the outcomes of the action/non-action or may involve how other people reflect back information about the health action/non-action (opinions, ideas, suggestions) to the individual.

The model outlined above has six phases. In the first phase, perception gained through the senses registers at a cognitive level in the translated state of "I seem...I feel...I am." In the second phase, self-perception registers through reflections about the body, actions, feelings, and visioning. This is the image of self in relation to health that gives one an indication of "how one is doing." In the third phase, one compares oneself to internalized ideal-self and shadow-self. This comparison produces an adjusted perception of self in relation to ideal-self and shadow-self. In the fourth phase, the adjusted and relativized perception becomes the subject of the question "How am I doing?" This question is re-examined a second time in light of contextual variables called patterns of meaning. In any given situation and at any point in time, certain patterns of meaning may be more influential than others. As such, patterns of meaning may validate judgements about "how I am doing" or may re-create another judgement about "how I am doing" that more accurately reflects an individual's current and immediate reality. In the fifth phase, the adjusted and relativized perception is again readjusted to take into consideration the patterns of meaning and the question "Should I act/change or not?" is raised. Patterns of meaning, grounded in the realities of daily living, enter the health thinking cycle at the judgment phase (about how one is doing in relation to health) and also mediate between judgement and action/non-action. That is, a judgement is formed yet patterns of meaning may constrain or motivate the actual implementation of action. In the sixth phase, based upon the appraisal of oneself in relation to one's life context, one decides to act or not act, and what specific action to take or not take. In some instances, there

may be a conscious decision not to decide about action or non-action. Action or non-action is assessed at an individual level through self-reflections, and at times, in interaction with other people in one's environment. Out of this assessment, new perceptions are formed, thus the cycle continues. The action phase may alter the self in relation to the world if self-reflection and others' reflections of a given action or non-action occur and are seen as meaningful for the individual.

The health thinking model is cyclical and spiral, and as such, is not necessarily conceptualizes as having a beginning or an end. What is represented above is one cycle of thought-action-living. Moving through the cycling of thought-action-living as outlined in the health thinking model produces a reality of "living the contradictions." The health thinking model represents the resonance back and forth between the person and the environment. Each cycle represents how perception is processed given one aspect of a given contradiction. Daily life, through interactions with self and others, are fed into the cycle through reflection. An example may help to clarify living the contradictions. Take Jody, in her abusive relationship with her spouse. Initial perception may be that she does not feel healthy because she does not view her relationship as healthy. Filtering this perception through parameters of health may reaffirm this initial perception that her relationship with her spouse is negatively affecting her health. Comparing her current perception with her ideal-self and shadow-self leads to an adjusted perception that she loves her husband and sees forcing him to leave as a no-win situation, especially as far as her children are concerned. Focussing on the ideal-self and moving away from the shadow-self means believing that trying to "save" her marriage is what any woman would do considering the emphasis on the family (cultural value). A judgement is formed in regards to how she is doing in the health domain. Using the adjusted perception based on comparisons to the ideal-self and shadow-self, and considering predominant patterns

of meaning such as survival (in Jody's case, this may be not creating waves) and responding by taking care, her action is not to force her husband out of the home.

Recycling this situation through the health thinking model again, additional self-reflections and reflections from others about her non-action in relation to her abusive spouse may reformulate her perceptions. Again, using parameters of health, she may be valuing visioning more, at an intellectual level know that she would be better off on her own, and integrate an understanding that she is not the "problem" that leads to abuse. Again, her ideal-self and shadow-self may come into play in that she works to avoid the shadow-self by not perpetuating the cycle of violence that she may have been exposed to as a child. Beliefs about marriage, her role as wife, and how relationship issues get resolved probably also enter the picture. All of these personal beliefs, values, and understandings, (predominantly) formed through ideology about what constitutes normalcy and therefore what constitutes deviancy, shape action and allow her to stay in an abusive relationship for a given period of time (non-action). When the original non-action is reassessed with additional reflection (self and others'), action to remove her husband from the household is the outcome. In this second cycling through of the health thinking model, different values may be placed on different phases, and certain emphasis on given patterns of meaning may be altered. For example, contextual influences of surviving and taking care as a method of responding may be involved with the non-action. With the action to remove the abusive husband, patterns of meaning such as personal healing and needs for self (as a method of responding) may take precedence. Living the contradiction allows her to stay in the relationship for a certain period of time, due to her understanding that having a man in the house is advantageous for her family. Recycling this given situation through the health thinking cycle again, certain self-perceptions (produced through interaction with environment) foster a contradictory message, one probably based on

past experience with therapy groups: that she shouldn't tolerate abuse. Other socially sanctioned norms foster self-independence and strength. Based on the value attached to the contradictory messages applied at a personal level, along with an added threat to safety, Jody eventually takes action to end the relationship.

Variables between thought and action

Moving into the lived world of the research participants allowed me glimpses of some of the variables linked with thought, and subsequent action or non-action. Learning about the multiple mediating variables between thought and action occurred through listening to the stories and daily life experiences of the participants. One kind of variable in the thought and action cycle is what I have developed into patterns of meaning (healing, surviving, responding, and good/bad medicine). Discussions about Native practices, racism, living situations, Native-non-Native interactions, and financial status inevitably emerged in the women's talk as other mediating variables. It is not possible to tease out how these specific historical experiences and situations influence current thought and action. Yet in recognizing these multi-layered variables, there is opportunity to further explore these areas in nurse-client interactions. Hinds, Chaves, and Cypress (1992) affirm the need to explore variables, what they term contexts, so that meanings can be shared between client and health care professional, and this meaning, translated to understanding, can promote meaningful life experiences.

At the outset of this thesis, literature was reviewed that outlined Native health issues. Among this research are social determinants of health among the Native population, like issues of poor housing and sanitation, alcoholism, violence and abuse, discriminations, and poverty. For the women living in poverty who were involved with this study, talk about their physical environments did not emerge in health talk. Other issues like alcohol, violence, and even the influence of poverty on self-image and self-esteem did emerge, and for some women were

salient variables especially as linked to patterns of meaning. As such, discussion about certain social determinants of health fit with the model described above in the area of judgements about how one is doing in living health, and may very well fit with concepts of the shadow-self and ideal-self (thus being foundational in how one is forming judgements).

I wonder if the lack of discussion about physical environment and living conditions was related to the fact that either the women felt that such things were not expected to be seen as significant and therefore did not talk about living conditions, or that living conditions are so common, and have been so engrained into their daily existence, that it does not bear mention. Another thought is that some of the women may see that their living conditions are somehow what they deserve, that this is "their lot" so to speak. If this is the reasoning behind lack of discussion about physical living conditions, then structural power issues may have a significant role to play. For those living in poverty and dependent on governmental assistance, victim-blaming may indeed be incorporated into the women's perspectives, in that they have incorporated the idea that housing is their responsibility alone. Issues like violence and abuse that were blended in talk about health may have been raised to the consciousness of the research participants over time, through socialization and experiences such as counselling, involvement in healing activities, words of the Elders, and informal discussions. Forming a critical consciousness about poverty and its far-reaching effects on health has yet to emerge on a large scale. Additional research is warranted in this area, especially in relation to the influences of structural power on personal integration of dynamics of social issues and health.

Discussion

Health care and health conceptions

The above descriptions of health meaning are in obvious contrast to a bio-medical conception of health (absence of disease) that is the primary conception structuring most of Canada's health care systems. Nordenfelt (1993) terms this conception the biostatistical conception of health and using the work of Boorse (1977), develops a neat description of health under the biostatistical conception. "Health can be defined in the following simple way: A is completely healthy, if and only if A lacks all diseases, i.e., if and only if all his or her bodily or mental functions fall within normal intervals" (Nordenfelt, 1993, p. 278). Normality reflects a species-typical pattern that is a statistically typical pattern (Boorse, 1977). A biostatistical conception of health creates a focus on disease within the health care system, and as such, is inherently problem and deficit orientated (Armentrout, 1993). The conception of health for the urban Native women in this study, as outlined above, is more consistent with health as correlating with human welfare, where individuals are viewed as interdependent and possessing characteristics of agency and ability (Nordenfelt, 1993). However, with the concepts of ideal-self and shadow-self blended into health meaning, a concept of normalcy shapes subjective experiences of health so that indeed there is an element of biostatistical meaning as well. Whereas our health care systems primarily function within a biomedical conception of health, operationalizing a human welfare conception would entail visioning "enablement" as the focus (Nordenfelt, 1993); strategies would be based on an individual's goals in terms of maximizing strengths (Mold, 1995). With such obvious disparities between a biostatistical model and the eclectic, multidimensional conceptualization integrating subjectivity and experience, it is no wonder that such activities as health promotion may be ineffective for such populations as urban Native women.

Another tangent of this discussion about health conceptions and health care structures is the role that structural power plays. Donahue and McGuire (1995) explain that structural power is "subtly embedded in social structures" (p. 47). Structural power can manifest itself in dictating action and perception. "In the case of health care, structural power may dictate: You must watch yourself to see that you control your body and your emotions to conform to our norms; we will specify how you may conceptualize health and health care in articulating your needs" (Donahue & McGuire, 1995, p. 47). And as such, structural power facilitates the persistence of the biostatistical conception of health, which has an emphasis on individual responsibility for disease, illness, and sickness. What the stories and exemplars in this thesis demonstrate is that health is intricately linked with the living of life. Based on this finding, social, cultural, and economic obstacles that constrain and limit health choices and actions demand attention because the physical body is not all there is to health; health is the embodiment of self as viewed through body, mind, emotions, and spirit.

Health conceptualization literature

A number of studies have been conducted that explore health meaning or conceptualizations for various groups or populations. Most of this literature has emerged within the last decade. This emergence may be attributed to an integration of the belief that health meaning is culturally and socially based, and the belief that health meaning is also individualistic. In addition, health professionals' views of health are not always consistent with lay peoples' views (Seedhouse, 1993) therefore, further emphasis may be given to exploring lay conceptions. Comparisons between existing literature on health conceptions and the main findings of this study are presented in the following section.

As a starting point, it may be useful to summarize the main findings discussed in the previous section. For the urban Native women interviewed in this study, health is viewed as

how you live your life, and as such, has elements of being a state as well as a process. In reference to health being a state, individual judgments are made in relation to how one fits into the ideal-self and the shadow-self based on the parameters of the body, actions, feelings, and visioning. Health is correlated with well-being. In referring to a process, health is the process of living one's life (choices, decision, experiences) and as such, the element of time is incorporated based on our evolving and historical nature. Blended with both state and process of health is the concept of balance between the four dimensions of self. For the urban Native women in this study, health themes and patterns of meaning echo the holistic nature of traditional Native view of health (Buehler, 1993; Ross & Ross, 1992: Royal Commission on Aboriginal Peoples, 1992; 1993).

Turning to health conception literature, several studies are based on frequency of responses in the study population, and then health meanings incorporate prioritizing health statements. Shea's study (1989) with Inuit adolescents undertook such a strategy. For Shea's participants, health meanings were categorized into three main areas: physical, social, and affective. The same categories of health are echoed in the voices of the urban Native women in this study, with the addition of a spiritual category, or that of visioning. The one research participant who did not specifically address spirituality was Peggy, the youngest participant. This causes one to question whether the value and importance placed on the spiritual aspect of self in reference to health is a development process. Interestingly, the research participant who placed the most value on spirituality and its role and meaning in health, was also the eldest in the group of women who were interviewed. A developmental perspective is found in Natapoff's (1978) study with children in that health conceptions increased in complexity and became more thoughtful with advancing age. Hanna (1989) also found age differences in health meanings for graduate students. Those under the age of 35 included both mental and

physical meanings, whereas with those over the age of 35, the majority of health meanings focussed on mental aspects. Hanna (1989) postulates that the greater focus on mental aspects with advancing age may be due to the developmental goal toward self-actualization.

What is unclear however, is whether it is development per se or the experiences that go along with evolution over time that is of importance in shaping health meaning. Mansour (1994) in her study with adult residents of Saskatoon (n=100) found that experience shapes one's definition of health. An example was "widowers and divorcees in this study agree significantly more that 'health is being in harmony with one's self' than did married people" (Mansour, 1994, p. 175). Experience as shaping health definitions reinforces the findings in this study that health is inseparable from life. Examining the concept of spirituality among the research participants, it is apparent that challenges in their personal life have been incorporated into health meanings and conceptions. For Peggy, her life experience may be limited due to chronological age, whereas for Monica, she has encountered many stressful, and challenging situations over time. Focussing on visioning, and developing a strong sense of spirituality may have been necessary for survival in several of her life situations. In this latter situation, spirituality may have more value because of lived experience. Mansour (1994) supports how one's values determine health conceptions. Mansour goes on to question whether it is health or wellness that is value laden, but this perspective assumes that wellness is the subjective meaning attributed to health. In this study, feelings in terms of "well-being" were linked with the emotional component of self, and were but one of the parameters that lead to personal judgements about health.

For the urban Native women in this study, health meaning was multidimensional, and perception of health (judgements about personal health) was dynamic. Many of the studies done with different population groups echo the finding that health meaning is multidimensional

(Colantonio, 1988; Kenney, 1992; Macran, Clarke, Sloggett, & Bethune, 1994; Saltonstall, 1993; Shea, 1989; Smith, Shelley, & Dennerstein, 1994; Woods et al., 1988). However, within a multidimensional construct, individual values play a role in what elements may receive more emphasis. For those individuals, like the urban Native women in this study, who live at the crossroads of several cultural realities, contradictions can occur so that several competing individual and cultural values may co-exist. McCormack and Gooding (1993) in their study of health meaning with homeless people, found that the participants combined physical, mental-emotional, spiritual, social, and environmental health aspects in unique ways which the authors attribute to differences in values. Again, experience and valuing certain aspects may indeed mandate how health is conceptualized. Long (1993) puts forward that rural conceptions of health are predominantly role performance related; work is the focus of many rural-dwelling individuals and highly valued. In a study of wellness with people with schizophrenia, valuing is manifest in research participants focussing on a thought category of wellness, in addition to action and feeling categories (Hamera, Pallikkathayil, Bauer, & Burton, 1994). Examples from the thought category include references to normal or positive thoughts; the absence of "bad thoughts" or hallucinations; and clarity, coherence, and sensibleness of thoughts. Here the subjective experiences of the research participants, that of living with schizophrenia, emerge in discourse on wellness. Implicit value is given to some ideal of what normal thoughts are (e.g, absence of hallucinations, coherence of thought processes).

The ideal of normalcy is integral not only to the conception of wellness for a sample of individuals living with schizophrenia, but also in reference to health for the participants in this study. Ideal-self and shadow-self are the foundations of self that are constantly used as multiple points of comparison. For the urban Native women in this study, there were four main parameters of health: the body, actions, feelings, and visioning. McKie, Wood, and

Gregory's (1993) research with women self-defining health resulted in a clear positioning of the body in health meaning. Body image was interwoven into the women's discourse, and specifically stating that they attempt to attain the "ideal body." Imaging of the body was apparent in the verbalizations of the urban Native women in this study in reference to weight, and the linguistic links in the talk about weight, eating, and exercising. Yet the centrality of the body in health is not a sex-specific or gendered finding. Saltonstall (1993) explored health meaning and actions for health using unstructured interviewing with a both men and women. For both men and women, health was viewed as a dynamic state and a process related to the lived body; what Saltonstall (1993) summarizes as "health was conceptualized as creation and accomplishment of a bodied, thinking individual" (p. 8). One aspect of the bodied, thinking self is the role of food. For the men, food was seen as a source of strength and fuel, and for women, food talk centered on dieting. This finding underscores the finding in the present research with urban Native women as to how ideal-self and shadow-self can emerge in health discussion and also demonstrates the cultural valuing inherent in gender construction.

Taken together, the parameters outlined above that structure health conception correspond with Smith's (1981) eudaemonistic model of health. The essence of the eudaemonistic model is "exuberant well-being" and includes clinical, role-performance, and adaptive models of health. For the women in this study, health as how you live your life encompasses dimensions of the clinical model (health as absence of disease), role-performance (performing roles according to social and individual mandates), and adaption (coping with interactions with environment). Yet the focus is not predominantly in one area, and the four components of self, along with a focus on well-being as a body-mind sensing, demonstrate similarity with exuberant well-being. And in many ways, the meaning of health as how you live your life (and it's focus on balance and well-being) fits with Dunn's (1961) concept of

high-level wellness that incorporates degrees of well-being, integration of self, dynamics in reference to becoming, and potential. However, from Dunn's perspective, humans move and strive toward an "ever-higher potential of functioning" (p. 6). This reframes high-level wellness to take on more of a goal-orientated concept rather than focussing on being and becoming.

Using Newman's (1991) two paradigms of health, in this study, the results seem to fit with the developmental paradigm in that experience, time, and contexts are integrated, yet elements of the continuum paradigm are evident in the research participants' focus on well-being as well as parameters of health in relation to functional ability. Newman puts forward that regardless of the paradigm, "health is viewed as a personal process characterized by meaning, pattern, and continuing development through the life process" (p. 238). Findings of this study generally fit with this view of health. Newman's two paradigms of health were formulated through reviewing literature published in the United States over a given period. How she formulated the two paradigms may have been influenced by ideology that fosters compartmentalizing and dichotomizing. It is impossible to tell from her review if cross-racial, cultural, or gendered samples were used. Given this situation, finding elements of both paradigms in the results of this study with urban Native women may reinforce their holistic understandings of phenomena while concurrently integrating mainstream (Euro-Canadian) ideas.

For the women in this study, balance is the pivot around which how you live your life revolves. Balance, in reference to health, goes back to Nightengale's writings that health is a natural balance; nurses were charged with manipulating that which is outside the patient so that nature could do its work and restore balance (Sharts Engel, 1984). Balance literally means to bring into harmony. Harmony was a pervasive meaning in Parse, Coyne, and

Smith's study (1985) examining the lived experience of health. Harmony emerged as part of a structural definition of health, in response to the question: "Describe a situation in which you experienced a feeling of health (Parse, Coyne, & Smith, 1985, p. 29). In addition, in Kenney's (1992) study, women were more likely than men to view harmony as a health indicator. In Ballas Daly's (1995) study with young adult Saudi women, a harmony category was ranked third in frequency of reported health categories. The focus on balance may also be influenced by Native cultural understandings, as maintaining balance and harmony are viewed as Native ethics (Pompana & Grumbly, 1994) or a commonality in world-view among different Native tribes (Renfrey, 1992). Balance and harmony are also consistent with the holistic health movement, in which balance is fundamental to wholeness of self in six areas: physical, mental, emotions, spirit, relationships, and choices (Montgomery Dossey, Keegan, Guzzetta, & Kolkmeier, 1988).

The finding that urban Native women in this study focus on parameters of health in their talk of health meanings is consistent with other published research on health conceptions. Morse (1987) in her research with inner-city people outlines that for the study participants, health is articulated partly through descriptions of physical indicators such as nutrition, sleep, physical control (walking, mobility, work, and exercise), and absence of disease. McCormack and Gooding (1993) also outline characteristics as the essence of health meaning in their study group of homeless people as the essence of health. For the homeless people, health was described as satisfying basic human needs, having no illness-related complaints, doing the work of health, fulfilling a functional role, having a positive self-image and outlook, being fit, having a support network, eschewing the use of addictive drugs, having good hygiene, and structuring the day. And in DeSantis' (1993) study with Haitian immigrants, health concepts were described through "multiple social and phenomenological definers...as a combination of

characteristics from the social-behavioral and phenomenological-feeling state dimensions" (p. 3). What is interesting is that all of these studies are with marginalized individuals - urban Native women, homeless, inner-city, and immigrants. The complexity of health is evidenced in multiple indicators of health. For these individuals in marginalized populations, it may be the complexity of their daily living and competing cultural values that become translated into multidimensional conceptions of health, therefore underscoring the links between health and the living of life.

One Canadian study was found that examined factors influencing perceptions of health for Micmac women living on-reserve (Ellingson, 1990). In Ellingson's study, grounded theory was used to determine that health, for the women in study, was creating a unified self; and that unified self had four dimension of thoughts, feelings, actions, and spirituality. In comparing the current study with urban Native women to the study of reserve Micmac women, there are several similarities, but also differences. The four dimensions that Ellingson (1990) outlines correspond to three of the dimensions found in this study; there is an overlap of feelings, actions, and spirituality (what I have labelled visioning). Thoughts are central to this study in that I am exploring health conceptions and as such, thoughts about health form the foundation, rather than a category of analysis as in Ellingson's grounded theory study. The salience of balance in also found in Ellingson's study. In addition, Ellingson provides interesting analysis on the spiritual dimension of health, stating that "an awareness of the spiritual dimension is time-orientated and patterned over time and generations [and]...[t]his dimension develops from one's perceptions and interpretations of sociocultural contexts" (p. 70). The finding that spirituality is linked with experiences and is integrated with time, lends additional strength to the finding in this study that health is inseparable from life, as there is a continuous co-creating of both based on experiences and contexts.

What is absent from Ellingson's (1990) analysis is the focus that the urban Native women in the current study placed on the body parameter as an indicator of health. There is a potential that the influence of cultural values plays a role in this difference, in that the two groups of women live (predominantly) in different contexts, with the urban Native women experiencing predominant White cultural values on a daily basis (and therefore, presumably, experiencing some degree of conflict in cultural values), and the Micmac women in Ellingson's study being enfolded in a more culturally consistent environment (reserve life). Such a hypothesis requires further examination and additional study. Ellingson does provide some credibility to this hypothesis however in her statement that "the dimensions of creating a unified self and unity are learned by observing and interpreting events in contexts. Therefore, time in context is needed to pay attention to the signs of unity/disunity that apply, reflect, and are related and reflected between contexts" (p. 153).

Several findings in existing literature contrast with the findings of this study with urban Native women. One such study is Viverais-Dresler and Richardson's (1991) examination of health conceptions with the well-elderly. For the elderly in that study, the bio-psycho-social meaning of health was predominant. Even though this meaning is multidimensional, the spiritual aspect is not salient. The soul of the person is not included in health meaning. It is plausible that the importance given to spirituality for the urban Native women in this study is a reflection of a cultural survival strategy where connecting with self, others, and a higher power is viewed as a method of cultural and personal survival as well as revitalization. The conception of health as how you live your life is also in contrast with Hatton's (1994) study with older urban Native adults. In Hatton's study, health ideas often reflected a biomedical perspective. Taking into account the historical underpinnings of this cohort's experiences (the participants ranged in age from 52 to 80 years old), it seems that

mainstream, Western ideas of health have been integrated into their understandings of health and reproduced in their daily lives. For the older urban Native (predominantly women in Hatton's study), assimilation of health values and meanings was effective; their voices reflect the influence of structural power. For the urban Native women in this study, life is blended with health. Cultural renewal and revitalization are seen as methods of healing the Native population and forging a path separate from dominant, oppressive (White) relationships is part of that process. So, the differences in health conceptions between Hatton's group and the women in this study can be explained in a large part by differing historical, cultural, and political contexts.

Culture and Health Meaning

As noted previously, culture does not have one universal meaning. When taking the perspective that culture is "in one's head" as cognitive models for shaping and interpreting behavior, applying this to urban Native women in general becomes problematic. One should not be distracted by the label of "urban Native women" as this is not a homogeneous grouping. What this research shows is that there are health themes and patterns of meaning in the discourse around health meaning that may indeed transcend the cultural and social labels that academics and scholars apply to their research populations, as well as the idea that health may have similar characteristics cross-culturally. To expand this statement, I had an interesting experience while writing the patterns of meaning section. After reading the section on responding to a friend of mine, she responded that she could hear herself in my words. This prompted me to question how much of health meaning is related to culture, race, or class, and how much is related to the fact that we enact gendered lives. My friend shared none of the social categories that the research participants share in that she is White, well-educated, and has a middle class to upper middle class family income. The one commonality with research

participants is similarity of biological sex. What this speaks to me of is that when exploring the essence of health meaning, stereotypes and assumptions about an individual based on her/his social and cultural labels can be detrimental in health and illness experiences. Rather than making assumptions about a person based on these labels, health meaning from an individual perspective requires exploration. Different experiences can lead to different outcomes or they may lead to the same outcome. Take the example of personal survival, something that may indeed foster how life is navigated. How one individual develops personal survival strategies may be quite different from another individual, yet the outcome is the same.

Another point, when speaking of the research participants, is that they stand at the convergence of many cultures. There is the Catholic upbringing that these women had, and the prevalence of Catholicism in the larger Native community, including the Elders who have a special place in the teachings that are perpetuated. There is the reality that these women have spent most of their lives living in urban areas, and many struggling to survive on social assistance. There is another reality of alcohol being prevalent in these women's lives, sometimes in their own lives, other times in the lives of family members. Salience of each of these cultures is not easy to tease out. Yet the multitude of cultures provides the background and context for meaning-making in regards to such concepts as health.

Challenges

Phillips (1990) challenges that nursing research move out of traditional health-illness research and into studying how people experience their health, and how health is constructed from a mutual process with the environment. For the urban Native women in this study, health as how you live your life is firmly embedded in the mutuality of self with environment. Health, conceptualized as how you live your life, is consistent with other published research in which health conceptions are found to be multidimensional and complex. In addition, research

in health conceptions reveals that individuals focus on different aspects within a multidimensional conception, and individual focus may be reflective of values. The biostatistical model of health was incorporated into their meanings as a referent for health comparison, yet it was not a predominant meaning. Focussing on health parameters is also consistent with other studies on health meaning found in the literature. More positive aspects of health were emphasized such as balancing the four dimensions of self, and visioning of present and future. For those women in this study with chronic disease, illness episodes are incorporated into how they lived their lives, sometimes by accepting and integrating, and for others, pushing away and ignoring physical symptoms were prevalent.

The focus on health parameters reflecting ideal-self and shadow-self may be attributable, in part, to the urbanization of the women in this study; most had only spent time visiting reserves and therefore probably have integrated mainstream understandings and philosophies about health into their personal health meanings. The salience of the body and weight demonstrates that [illegible] individuals are not immune to idealized self as structured and reproduced through socialization methods in Canadian society. At the same time, a resurgence of "Native values" as put forward through the teachings of Elders with whom the research participants are in contact, and through the teachings of the Centre, fosters the expansion of health conceptions to include healing and spirituality. I postulate that what specific aspects of a multidimensional conception of health are emphasized by a given individual are linked with personal values and experiences gained through the living of life.

Because this is a qualitative study, there is no way to make cause and effect linkages; rather, by presenting and discussing the multiple and complex contexts of these women's lives, one can ponder the interactional effects of daily living and health meanings. I have presented my understanding of this interaction in the health thinking model which reflects "living the

contradictions" that are inherent in everyday life. This research focusses on the common elements and boundaries of health for the research participants; I have not compared and contrasted at an individual level. This type of analysis could provide valuable insights into how health can be individualized if enough information is known about a woman's multiple contexts. In addition, examining how the dimensions of health are related and inter-related may prove fruitful in coming to an understanding of health thoughts and actions. Expanding this beginning research to include perceptions of individual and collective agency in relation to health is also warranted given the finding that health is multidimensional and mediated through the living of one's life in context. There are also several concepts emerging from this beginning research that require additional exploration. Exploring such concepts as the doing of health, healing (and it's linkages to health), shadow-self, and valuing would contribute additional theory to our understanding of health and health actions.

Linking micro-level to macro-level

Health conceptualizations really are about individual thoughts and behaviors. That is, conceptualizations are largely cognitive processes situated within individuals. However, individuals act and interact within a social system where the interplay between and among macro-level variables such as inequality, discrimination, and ideology influence thoughts, behaviors, and beliefs. Patriarchal ideology organizes society in such a way that women must constantly navigate, balance, and negotiate the ideologies and the actuality of their experiences as women in a hierarchial world. Women classified as "minority women" (Native, African-American, Hispanic, Asian) may have an even larger task and "minority women" is lower social strata an enormous task of navigating the division between socially dictated reality (that constructed by ideologies) and their lived experience of reality.

Reflecting on the stories and experiences shared by the research participants explicated

for me what meaning is about in relation to health. Meaning is relational, it is negotiated, and it is context-laden. The phenomenon of health cannot be separated from the reality of daily life, from personal contexts, and from social realities. Health and life circumstances are influenced by social and environmental facts. To tease out health conceptualizations from such mediating factors as race, class, and gender seems sterile and inappropriate.

If one were to look simply at these women's stories without an understanding of the influence of macro-level variables, there could very well be a tendency to label and stereotype in a negative manner. The result of negative labelling and stereotyping leads to context-stripping (Mishler, 1986), a situation in which the richness of context is not considered, or consulted. Taking Margaret as an example, context-stripping means that her strength to overcome challenges she has faced is not considered, the fact that she views herself as adaptable because of what she has gone through in her life would not be known. Through a process of context-stripping, either consciously or unconsciously, an individual is transformed into something that he/she may not be - that is, the observers and outsiders re-create the individual based on their own life contexts rather than focussing on the contexts of the individual (client or patient). Context-stripping also reflects an ideology of individualism: what is wrong with someone is that they are deficient in certain areas, and these deficiencies are based on personal characteristics.

In Margaret's case, an outsider may say that she lacks the insight to leave an abusive husband, that she lacks the intelligence to find gainful employment, or that the problems she is experiencing with her children are because she doesn't know how to parent. Again, ideology has a significant role in the process of context-stripping in terms of cultures, socialization, and learning. That is to say that meaning is developed in context. In addition, race, class, and gender, in interaction, determine individual's images and one's place in the world (Robinson,

1993). In order to accepting the richness and diversity in others, we need to understand the interaction, and constant negotiating, of reality that encompasses social reality, and subjective reality (personal context). From a nursing perspective, those involved in the discipline must be aware of the destructive process of labelling, stereotyping and context-stripping so that "whiting-out" difference (Jackson, 1993) is avoided.

Summary

This research began as a description of health meaning among urban Native women Based on the interview data, in many ways the research I undertook uncovered more than health meanings, because the women's discourse included personal narratives about experiences. The narratives provided contextual information and sequences in which the women revealed their thinking about health. The model of health thinking is what the research participants were telling me about their health, and about the deliberate decisions they make in relation to health actions. If one cycles through the health thinking model, incorporating the dimension of time, one begins to understand the process of living the contradictions. The contradictions emerge in subsequent passes through the cycle. For example, referring back to the health thinking model, striving for the ideal-self while avoiding the shadow-self can be interpreted as a cultural value. Yet from the women's discourse, striving for this ideal, although it is internalized, is difficult to translate into action because of other competing cultural values, such as family being more important than the individual. Taking this latter example, self-care wants and needs of a single mother are pushed away or ignored for (sometimes) extensive periods of time because her roles as mother and provider compete and win over the value of attending to self-needs. The cycle, living the contradictions, can help explain the complexity of health actions. The patterns of meaning in the cycle become mediating lenses between thought and action, and personal, social, and cultural contexts

provide additional understanding about how thought can be transformed into action or non-action.

Our Canadian health care system has taken as its primary foci medical necessities and health problems. Health promotional strategies are taking on the American proclivity for focussing upon lifestyle. As a result, these strategies are often aimed at curing, eradicating, or otherwise fixing the individual. Often an element of fear may be operating in order to exact compliance from the individual (e.g., don't smoke or you will get lung cancer). What the findings of this study show, is that health conception is multidimensional, is not primarily focussed on problems, and is related to personal and cultural valuing. Actions for health are the complex output of thought-action-living and recycling through health thinking produces situations of living the contradictions. Given these findings, health promotional strategies would be better organized around mutual goal-setting with clients, groups, and communities based on their valuing, and the complexity of everyday life, not simply concentrating of altering lifestyle to fit with an allusive ideal of health. A model for nursing practice that is emancipatory, advocating, and inclusive of multiple views is necessary for valuing the diversity of individuals' perspective and negotiating care within the health care environment. Using this type of approach focusses on individuals in such as way as to validate and authentically work with people in their contexts, rather than imposing "outsider" structures and meanings that creates the contexts for individuals through objectifying practices. Using a negotiation framework with an understanding of health thinking (as put forward in the health thinking model), nurses may interact with clients in the reflection phase and this interaction may lead to altered perception and altered action in relation to health. Living the contradiction needs to be incorporated into nurses understanding of health in everyday life, as this is a

means for grounding health with the individual in their daily context, rather than extracting the individual from context in order to address health needs or issues.

I wonder if I have truly answered any questions with the research I have undertaken. Yet in the same breath I say that is not the only issue, but also the experience of learning about research and through this, about other people. I have travelled to others' worlds, and my box has truly been expanded. My initial idea that little in this world is black and white has been affirmed, especially through undertaking such a vague task as trying to gain an understanding of the meaning of health. I have come away from the research experience with three main learnings: a) health is about living, yet ideals often structure the living of life, b) from the perspective of the research participants, health is a process and is blended with the path of healing, and c) meanings evolve in context and as such are constantly being formed, reformed, and transformed. Having some understanding of what health means to an individual provides some starting point from which to interface at a professional level so that nurses can foster health from the perspective of the client. This is not to say that all health promotional strategies and teachings are "wrong" because they are not individualistic and they are based on a biomedical model of health, but rather to say that through discussion, negotiation, and true dialogue, issues can be explored and addressed in a manner that is congruent with "working with" the client instead of "doing for" or "doing to."

Closing

> Health is a personal commitment--only I know me. Health is my own living of values. I constitute my health with my mutual interconnectedness with the world. The nurse's true presence with me calls me to learn the meanings I give to situations but *in me* and my world is "the way"--I know it in my tacit-explicit--I know it at all levels of my universe, in ways I cannot say and that no others know. Health is how I live my life--my own personal commitment to being the who that I am becoming...Listen to me nurse, when I tell you how I am, and what I will do - since that is how I am going to be me (Parse, 1990, p. 140).

Endnotes

1. According the a Health Canada report (1994), new registrants from successful application under Bill C-31 are expected to add over 17, 000 to the population of status Native people by the end of 1994.

2. Positionality is used here in reference to the positions that I hold as both as an individual and a researcher. These positions are derived from the multiple aspects of my identity (such as race, class, and gender), and can change based on contexts and experiences (Maher & Tetreault, 1993).

3. Reflexivity is the awareness that the researcher is part of the research environment, that she influences the process, and in turn is herself influenced by the environment and those people in the environment (Boyle, 1994; Hutchinson, Wilson, & Wilson, 1994; Lamb & Huttlinger, 1989). The term also incorporates the "dynamic and mutual influence of the ethnographer and research field on each other" (Mueke, 1994). In effect, reflexivity addresses the relational aspect of interactions and environment of the research process and brings this issue to the conscious level.

There are two designations for Native people in Canada. One is either classified as "Status" or "non-status." Status Native people meet the requirements of the Indian Act (1876) and are registered under the Act. The criteria is to have one parent who is registered as a Status Indian or being a member of, or a descendant of, a band that has signed a treaty (Ministry of Aboriginal Affairs, 1995). Non-status therefore, are not eligible under the criteria as set out in the Indian Act, or in some cases, have not been registered as a Status Indian despite meeting the Status criteria (e.g., Métis).

The Indian Act is commonly thought of an assimilation objective to assimilate Native people. In its original form, this act made provisions for the following: "the definition of "Indian"; the recognition, protection, management, and sale of reserves; the payment of moneys to support and benefit the Indians, including, specifically, 'contribution to schools frequented by such Indians'; the election of councils and chiefs; Indian privileges, particularly the exemption from taxation and from debt obligations of all types; provision for receiving the 'evidence of non-Christian Indians' in criminal prosecutions; special measures for the control of intoxicants; and provisions for enfranchisement" (Armitage, 1995, p. 77-78). The latter provision for enfranchisement meant that a Indian male (any by extension his immediate family) could legally cease to be an Indian through either demonstrating the ability to effectively farm, or by becoming a minister, lawyer, teacher, or doctor (Armitage, 1995).

One service afforded to Status Native people is medical coverage and non-insured health benefits (e.g., eyeglasses, prescription drugs). The premiums for the aforementioned services are paid for by the Medical Services Branch (MSB). MSB is a division of Health Canada and is responsible for providing health services to the Status Native population who reside on-reserve (Health Canada, 1994).

5. I refer to gatekeepers as anyone that can facilitate or restrict access to potential research participants. In application to this research, gatekeepers were those individuals involved primarily in administrative roles that have sanctioned power within the agency to grant or refuse pennission for research.

6. The life skills model was being used at the Learning Centre, and found to be ineffective in meeting the needs of course participants. This model gave credit to such courses as English, Math, Socials, and Science and then there was a non-credit component of life-skills, such aspects like budgeting, anger management, conflict resolution. Using a life-skills model devalued personal

affective components and presented the perspective that somehow course participants were "lacking" and that the life-skills teacher had the knowledge to impart about these aspects of living. The life-skills model is viewed as hierarchial, deficit-orientated, and problem-focussed (fieldnotes).

7. Literature typifies Native and non-Native interaction as an oppressive one, that of the colonizer and the colonized. This theme remains pervasive in current literature (Finkler, 1988; Langford & Ponting, 1992; O'Neil, 1984; Pavelich, 1992). Several examples help to explicate the relationship between Native people and White (Euro-Canadians) people. Sherley-Spiers (1989) studied perspectives of Dakota Native and their interactions with health care professional (predominately physicians). Although this is an American study, the issues of victim-blaming, stereotyping, and specific examples of overt discrimination speak clearly to concepts of power, respect, and valuing. Young's (1984) publication on the history of health services for Native people in Canada describes the implementation of health care services for Native people as "not altogether altruistic in intent" (p. 260). Young (1984) goes on to address a more covert reason that health initiatives were formed:

> A less obvious reason was that, under the then prevalent philosophy of "civilising" the Indians, health services were seen as an integral part of the policy of total assimilation and elevation of Indians from "wards of the nation" to full citizens. The dominant philosophy can be described as benevolent paternalism (p. 260).

Frideres (1988) echos Young's perspective in relation to Native health services as he believes that the federal government's agenda has always been to "maintain close control over them in almost all aspects of their lives" (p. 136).

8. According to one anthropologist involved with community-based research in Northern Alberta, there were up to twenty (separate) research projects occurring simultaneously on one Native reserve (personal communication R. Ruttan, May 26, 1994).

9. This concept of a box of personal knowing, expanding the box, and implications for practicing and teaching nursing was developed in discussion and interaction with Dr. Terry Davis. This concept has remained in my consciousness for the duration of this research project, and acted as a philosophical guide to my interactions with both research participants and people I met through my activities at the Centre.

10. Smudging can be partly explained through addressing the use of sacred fumigants. Simply put, these fumigants, such as sage, juniper, pine needles, and sweetgrass, are burned in a small vesicle and the smoke is used to "purify the place, participants, paraphernalia, and offerings used in ceremonies" (Paper, 1989, p. 5).

11. I am indebted to Dr. Eileen Jackson for her insight and comments about this model. Often it seemed that she was able to verbalize about that which I did not have the vocabulary to share.

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Appendix A
Guiding Questions for Interviewing

1. Tell me what health means to you.
   - what makes a person healthy?
   - how does one go about being healthy?
   - how do you feel when you are healthy?
   - tell me about a person that you think is healthy.

2. What do you think health is?
   - what are some words that co[illegible]ind when you hear the word health?
   - why is --- health versus ---[illegible]?

3. Is health important? If so, why?

4. What is the relationship between health and disease or illness?

Appendix B
Consent to Participate in Research

PROJECT TITLE: Conceptualizations of health among urban residing Carrier women.

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CO-INVESTIGATORS:

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Purpose: The purpose of this study is to talk with you about what health means to you. How you define and think about health, how you feel about your health, and what you do to get and stay healthy will be topics of conversation. I am interested in hearing your stories about everyday life and your experiences. There has been some work in this area with White people. Little has been done with Native women who live in cities.

Procedure: Your name may have been given to the researcher by someone at the Centre, by one of your friends, or the researcher may approach you directly. The researcher will talk to you about maybe being in the study. If you decide to be part of the study, the researcher will get your name and phone number (or how you can be reached) and set up a time to meet and talk with you. There will be one to four meetings, each about an hour long. Phone calls may be done as well. The meetings will take place at the Centre and they will be like a conversation. These meetings will occur over a period of time, and be arranged when you say that you can meet with the researcher. What is said during the meeting will be tape recorded, and parts of the conversation may be written down as well.

Participation: There is little risk of harm to you if you take part in this study, nor will there be any direct benefit. Results of this study may help nurses to better understand the meaning of health for Carrier women. This in turn, may help nurses give better care in hospitals and in communities.

You do not have to be in this study if you do not want to be. If you decide to be in the study, you may drop out at any time by telling the researcher. You do not have to answer any question that you do not want to. What you tell the researcher will be kept confidential.

To protect your anonymity, the researcher will do the following: your name will not be in the study and you will be given a code name in all records. These records will be kept in a locked file. These records may be used to teach others, for writing papers, or for giving talks at conferences. Another study may also be done with the records, but this would depend on getting ethical approval The tapes used to record our conversation will be kept in a locked file for seven years and then destroyed. This written consent will be kept locked up for five years and then destroyed.

Consent: I agree that the above information has been talked over with me. Any questions have been answered well. I know that I can phone the person named below if I have any more questions. I understand that there are no direct benefits to me in being part of this study. I have been told that records of this study will be kept confidential. I know that I am free to leave the study at any time. I understand there will be no consequences for leaving the study. I have been given a copy of this form to keep.

_____ _____

(Signature of Participant) (Date)

_____ _____

(Signature of Researcher) (Date)

IF YOU WISH TO HAVE A SUMMARY OF THE STUDY WHEN IT IS FINISHED, PLEASE WILL OUT THE FOLLOWING INFORMATION:

Name: _____

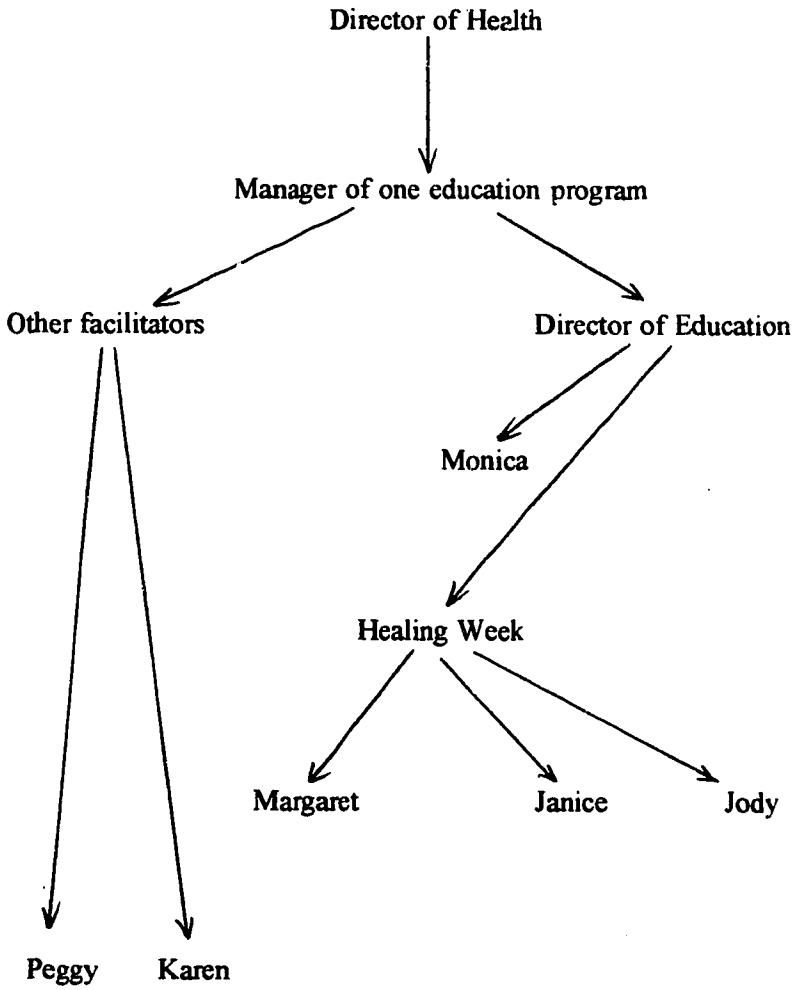
Address: _____

_____

City: _____

Note: The above consent was used with the research participants. After the inclusion criteria were modified, I explained to the woman signing the consent that I was not limiting the study to Carrier women but rather had broadened my scope to include (self-defined) Native women.

Appendix C
Contact Mapping



Appendix D
Healing Week Evaluation

The following are excerpts from the Healing Week Evaluation submitted to the Learning Centre near the end of January, 1995. One category of analysis is not included due to the fact that this focussed primarily on institutional and organizational issues.

Evaluation Format

In order to organize the evaluation in some systematic fashion, I contemplated how best to collect information that truly reflected individual's perceptions and experiences at the healing week. I made the decision to use an unstructured interview format, in keeping with a qualitative type of data collection method. To provide some initial focus, a similar lead question was asked of all those interviewed. Interviewing is a direct means of obtaining information regarding beliefs and perceptions (Pearsall, 1965). In addition, interviewing is an efficient way of gathering large amounts of data in short periods of time (Marshall & Rossman, 1989). Interviews provide for a richness in communication that is unattainable through written or survey-type data collection methods (Gorden, 1987).

Informed consent was implied through the fact that individuals engaged in the interview, rather than the evaluator specifically seeking out formal written or verbal consent. Confidentiality is maintained with written information in that names are not be used in the final document, and information that could identify an individual is excluded whenever possible.

Some biasing in the collection of qualitative information is always present, and often unpreventable. Because of this reality, identifying possible bias is essential rather than presenting information as being neutral and objective. The evaluator considered the following as possible influencing factors in the data collection:

1. The fact that the evaluator was White and the vast majority of those interviewed were of Aboriginal decent. There is a potential for racial influences in communication patterns, the level of trust, etc.
2. The fact that an open format was used to collect information, meaning that the direction that the interview took was largely dependent on the direction that the interviewee took, versus the "agenda" of the evaluator.
3. The fact that the evaluator attended the healing week, as a nurse and a participant.
4. The fact that the evaluator may be viewed as an "outsider"
5. The fact that the evaluator has no vested interest in the outcome of the evaluation itself (e.g., is not a key organizer and is not an employee of the Native Learning Centre).

Evaluation Process

Individuals were approached, in person or by phone, by the evaluator. An outlined that the intent of the interview was explained, and individuals were asked if she/he would be willing to talk to the evaluator. One person did not return my telephone messages. All others agreed to be interviewed. Meetings occurred when it was convenient to the individual. The majority of interviews occurred in a private space at the LC; a few telephone interviews were conducted as well.

A concentrated effort was made to contact participants first, and to accomplish those interviews before the Christmas break. By in large, this was goal was met. A total of thirty-three individuals were interviewed. Interviews lasted between fifteen minutes and ninety minutes, on average about an hour. Notes were taken throughout the interview, and these were later transcribed into full written format on the computer. Attempts were made to record as accurately as possible the actual responses of the people interviewed. Topics or issues that emerged from previous interviews were at times brought up in subsequent interviews for further information collection.

Interviews were read over several times as a means of establishing recurrent themes. Fifteen themes were then developed based on information collected through the interviews. These themes can be grouped under three main categories: a) community, b) intra/interpersonal, and c) planning and process. Specific recommendations for change are summarized after the theme section.

Interview Themes

A. COMMUNITY

Community

Respondents felt that the healing week was a time of community building, developing community spirit, and bonding as people. Community in this sense is that of togetherness, shared concern, and mutual respect. Inherent in the developing sense of community is a trust of other people and establishing new friendships and connections. Participants felt safe, and because of this, several were able to move out of their "comfort zone" and explore new ways of interacting and relating to other people. Learning about themselves, others, and the Native culture fostered the sense of community for participants. One participant shared her perspective:

> I didn't expect anyone to be close, and everyone got really close. Everyone is alot closer, we understand better - how people act and why they act the way they do. I learned alot of culture. It was kind of nice to learn different things, kind of nice knowing why we do this. The togetherness, how people felt, how easily you could talk with your teacher, there was no authority. They are people too.

The bonding of participants was demonstrated in recounts given by respondents in the different atmosphere of the bus ride down versus the bus ride back: "The bus ride back, the ride down was quiet. On the way back people were dancing, happy, and talking and singing with the guitar."

Connecting

Connecting as people was demonstrated through the comments that respondents made about touch - affirming and reaffirming each other through the use of touch, and also showing caring through this activity. The elders commented on the touch element; that there was hugging and touching in a positive and good way. From their perspective touch has become taboo in that

small children today are taught that "touching is bad" and this often translates to all forms of touching. They were glad to see touching and hugging at the healing week, as a way of showing caring, and connecting as people.

Another aspect of people connecting were the comments made by participants regarding the friendships that were established as a result of healing week, and the closeness they felt with each other upon returning to the LC environment. One respondent captures this aspect when asked *"What comes to mind as the most salient, what is most prominent in your mind?"*:

> Friendships. That was the highlight of the whole thing. The people that go to school here - good friends are hard to find - I found some here.

Another respondent links touch and relationships, under the umbrella of community and how participants are connecting, in the following manner:

> It comes back to relationships, how safe our youth feel. Seeing youth that attended, and walking by them in the hallway, they stop and give me a hug. It is a meeting. Long after they have finished with their process here, these relationships will still be a positive force in their lives.

The above statement ties together how relationships and connections build and strengthen a sense of community, and a sense of safety through belonging and valuing.

Elders

Almost every respondent mentioned the impact of the elders. They were viewed as giving legitimacy to the healing, they were the strength, and the grounding. One respondent spoke of the elders as the "safety net", another spoke of them as a "support system." Regardless of the language used, the elders were viewed as powerful, wise, and central to the events that occurred at the healing week. For some, talking and consulting the elders was a new experience, for others it was renewing a resource that they once had, but had been lost over time. Three comments reflect the saliency of the elders in the healing week:

> I was really impressed with how the elders were used. They are developing their rightful place in our healing and our teaching. When obstacles came up they were involved in the problem solving.

> I didn't have expectations of the elders, but that really blew my mind - what they did and people's responses to them. I wonder how many times they are invited to legitimize events, they did that, they legitimized the healing week. From them came the message that it's not all fun and games, that it is about community.

> Their [elders] input was so powerful. They didn't even know us. They too put their trust in us, to be there for us, to give support and encouragement...I saw how they were there for everyone. They are all in their eighties - and they were there from morning until night. I see that elders will continue to be key people, they are the structure.

The elders said that when they were growing up, there was always someone there to help them out, to answer their questions. The adults usually stopped whatever they were doing to attend to their needs and questions. They felt that this same thing doesn't happen today. So in a way, the support, attention, and caring that may be lacking in the day to day lives of Aboriginal people today was played out in the roles the elders assumed during healing week: listening and advising, praying over people, showing their caring through their presence and their touch, and speaking in circles.

B. INTRA/INTERPERSONAL

Relationships

The issue of relationships was raised by several respondents. There was concern expressed that people at the healing week were "vulnerable" and because of this, relationships tend to develop, that may or may not be beneficial to the individuals involved. A second component of the relationships theme was existing relationships being deeply affected when the participant came back from the healing week. Several comments capture the relationship theme succinctly:

> It was hard coming back. I almost left my husband - he said that I had changed. Normally I would just go for a walk or leave when we fight, but I went back and talked to him. And he started to cry, saying that I had changed. We worked things out.
>
> And assessment of relationships. If they go away to healing week they may come back separated or divorced.

To complicate this issue of relationships, was the fact that healing week was a multi-generational gathering, with minor (youth) present as well as adults.

Readiness

The theme of readiness is addressed in a number of interviews, although the word itself is not used by the respondents. Readiness reflects the personal decisions and commitments involved with participating or not participating in certain events. Readiness also reflects where an individual is at in their own personal healing journey. Some participants spoke of wanting to "check things out" before partaking in activities such as the breath work. Others spoke of "fighting" or "resisting" or "trying too hard" with the healing activities.

The following comments by respondents further exemplify this theme of readiness:

> Healing is personal, you have to want to do it. But people also need to be able to check it out. *(What about the people that "weren't ready"?)* There were a couple of them that hadn't experienced it before, both said they would go again because they have more understanding of what goes on.
>
> It was time to let it out [anger], I knew it was the right time.
>
> I have done this type of thing before, but I wasn't prepared for the pain. People wanted it. That was the difference.

Helping, Safety, and Support

The theme of helpers and those doing the healing activities was raised by several individuals that were interviewed. This is somewhat of a difficult concept to articulate due to the philosophy of the Native Learning Centre, and the perspective of healing as personal and community revitalization. The preliminary work that was done around the healing week focussed on the fact that all people attending the event were going as participants, that is, all would be equal there.

As one individual put it "one potential problem is people with issues working with people with issues." Another spoke of the theme in this way: "everyone has healing hands is sort of a dangerous message...yes, maybe we all have capable hands, but right now they may be abusive hands. With trauma in your life you have to find your healing hands." The following interview excerpts attempt to explain the complexity of helping, creating safety, and offering support:

> It's hard to put trust and security in someone that is having emotional times and may not be stable emotionally. I think that there should have been people appointed: so and so will be doing healing week and so and so will be a supporter. It was a scramble - and hard to know if the facilitator would be falling apart at any minute.
>
> Even before leaving, it was said that the staff and students would be healing together. It was presented that that would be good, we would all be on an equal basis. In our ways, that is not so - the medicine people do not heal with those asking for healing. There is a belief that your can't take those asking for healing farther than you have gone yourself; you don't do this with colleagues. The people need to know, those doing the healing, that the people working with them are strong enough to help them.
>
> The participants still look to us, even though we all went as equals, to help them move through things. At some level, I'm not sure what, we weren't there for them...The first day [of breath work] we were all kind of thrown in. Yes, we were all there as equals. But if both the one doing the work and the helper are at the same level, that may open up things for the helper, then can they really be helpers?

Tied in with this theme and the issues around helping, safety, and support are the roles that people assume, and the perceptions of responsibilities that are linked with certain roles.

Roles

There are boundaries that people establish as part of who they are, as defined by the roles that they enact in their daily lives. The following comments address the dynamics of roles and boundaries:

> The people that have had the most difficulty have been the facilitators (from what I have heard). I can understand this to a certain extent, especially under the influence of the Western model, that professionals don't have problems. If healing week stirs that, then they try and get the anchor back by negating.

> Facilitators saw themselves in the helper role but they were the ones that needed help. The participants handled it better. Like one said, "what have I got to lose?" But the participants don't know all the facilitators' problems. It meant that everyone had to be real. I need to say that when I talk about this, it is a very small number of facilitators. But they had a very large effect on things that happened there.
>
> I don't feel that it is appropriate to be a participant in a week like that and looking to help other people. I guess my belief is that people can take care of themselves, and seek out the help they need. I get frustrated with the us/them perspective. People that get confused with their roles may be those that are afraid to let go of the role of facilitator; they are afraid to be a participant. I think that this gets back to the feeling of community, of equality - there was a strong sense of community. We were there for and with each other and ourselves.

When boundaries are evaporated through equality of relationships and participation, self perceptions may be threatened, and a sense of vulnerability develops. There may be more at stake for the facilitators to show this vulnerability than the participants. The above comments capture the dynamics of roles in relation to healing.

OVERALL ASSESSMENT

From the tone of the interviews, the healing week was seen as something that was important and valued. Of the twenty written evaluations that were returned, seventeen said that they would attend another healing week. Even though some had negative comments, and many had suggestions for changes, respondents were supportive of the concept. One indication of this may be the length of time people spent in interviews with the evaluator. And many shared their personal issues with the evaluator. This might be interpreted in two ways - that there was not closure for the individual and he/she still had alot of need to talk and discuss, or that the individual has opened up and trust is increasing so that personal issues can be shared in a positive manner (sometimes for the benefit of others). People were appreciative of the time, and energy that was invested in the organizing of the healing week. What is so salient in the interviews is the weaving of a sense of community through personal relationships and personal change, with the elders being the grounding.

Appendix E
Native Women Tell Their Stories - Condensed Interviews

Edited interviews of the women involved in the research are presented here. It is not possible to present the interviews in their entirety, so what unfolds in subsequent pages is the telling of individual stories over a period of time. What has not been altered is the temporal nature of the interviews, that is, how the data is presented here is true to the actual chronological flow of the interviews.

Margaret

The first question that I am going to start with is kind of a broad one, asking you to tell me what you think health is.
Well to me, the first thing I think of when you say health is, because of my condition that I am in is breathing normally - that is what health is to me. *OK.* And, being able to do things, like getting out easy, not having a problem with getting out to the store - whether it is breathing or being overweight, having problems with that, or...that's, being able to breath normally and do the normal things I think. Going to the store, or the bus, waiting for the bus in this cold it is hard for me because I can't breath. I have an asthma attack because of the cold air, that's not normal to me. *Ya.* Normal to me is not even thinking about it.
What about for your kids, what does it mean for your kids to be healthy?
Uh, actually I picture my kids as being healthy as they are, they are not overweight, they are not underweight. They are the right size for their weight. They are not lacking alot of energy, they've got enough energy. More than enough energy sometimes [laughter].
Then you have to deal with the repercussions of that [laughter].
But they are not sick all the time, they don't catch colds easy, you know, they are healthy to me. *Ya.* And they do not have any major illnesses, or anything like that. As far as my kids, they haven't had any problems that I can think of, other than measles, chicken-pox, childhood diseases. They have been pretty healthy. When I first left my husband, I had a hard time keeping food on the table for them. Once we split up, I had to learn to do things in a different way, like with less money, less, you know, resources. *Umhum.* So, I had to work around that, to put it on the table for them. But I am learning, we do pretty good. We have fruit all the time, and vegetables, and their milk. I have learned alot of ways to watch my money, to budget, to you know, get the most out of things.
[*This theme of resources, and accessing resources comes up again. I ask how things are with her*]. To this question, Margaret shares that someone at the Centre has given her a number for Parents in Crisis - she thinks that she will be phoning them everyday [laughs]. Margaret is not sure that she would fit in, but thought that it was worth a phone call.

Her second youngest (Jill) is swearing at her all the time. Jill isn't going to school - she gets up when Margaret tells her to in the morning and then she goes back to bed after Margaret has left the house. Her oldest daughter (Jan) is "hard to deal with as well". Both Jan and Jill lived with their father after the marriage split up. Margaret feels that the girls

"don't have alot of respect for me", her younger kids have more respect for her. She thinks that part of this relates to seeing her physically and emotionally abused.

Her husband was a drinker; she left six years ago. Margaret says that her husband "couldn't understand when I said that I was leaving. He wanted me to tell him what he had done. I told him all the things, but he couldn't remember because he had been drunk." She moved seven times in two years, living in five different cities. She felt that she was harassed, he called, he followed her to each city. Over time, she has moved to follow family. Now Margaret finds parenting difficult because she doesn't have much support from her nuclear or extended family.

She speaks of a man here in town. "I had spent most of my money over the holidays, especially with travelling and dad being sick. I borrowed $20.00 from him to buy some groceries; that would tide me over until I got my cheque. So we went shopping together. He came back to the house for a little while. When he left, he left half of his groceries.

[*Margaret talks of experiences with her eldest daughter*].

Jan started hating, well, disrespecting me, when she was about twelve; that's when she started getting into the drinking. And doing drugs - smoking up and things. Going to the hospital, like when she had [overdosed], that was really hard. She was doing drugs; and she would be swearing and screaming at me - I knew that I was the last person on earth that she wanted to see at that moment. That's hard, it really hurts me. Trying to separate my feelings from what is best for her. And I am still working on that now. Feeling hurt by what the girls say or do, and trying to do what's right. What's right for Jill isn't necessarily what's right for Jan. I really wonder if I do the right things with them. I think I should be able to give them options; do things they like doing and talking to them. It's easier with the younger ones. They have more respect. I was trying to build up my self-esteem at the same time that I was trying to help Jan with hers. It gets better with time, you know what I mean? That each kid seems to be a little better that way. Like Jill has better self-esteem than Jan did at her age. And I am really working with the younger kids on that.

[*Parenting issues remain salient through most of Margaret's discourse*].

It's been hard. Actually, I feel OK now about it but like every day at the end of the day it seems like a hard day, but now that I look back on last week it wasn't so bad. Well it was mostly the kids and having trouble with my own patience with them. I seem to be running out of patience with them. When I get home, things that I have to do when I get home, I want them to help me, but they're not. I'm having a really hard time with that.

Do you think some of that ties in with the lack of support that we talked about before?

It's, ya, I really feel that I have barely any support systems other than here, and it's not really much here because I'm here to do my academics, other than that I don't really talk to other people about what's going on, other than this. I don't get opinions for anybody about what I'm doing, like I'm not taking anything and I'm not telling anyone, so. I think that is what has alot to do with it, why I'm at the end of my rope. And finding someone is kind of hard because I tend to think that everyone has their own problems and I don't really want to add mine to theirs, like my friends. I don't want to burden them, the friends that I have here. I'm just getting a few friends now.

You don't want to "dump" on them. And that is difficult too because I think that even establishing those contacts takes energy, for me anyway it does.

Ya, it does. And uhm, maintaining friendships is one of the hardest things for me. Because if I get busy, if I have something going on at home with my kids I tend to ignore my friends. And the opposite with my kids too, if I have made new friends I want to develop that friendship, I don't ignore them, but I don't see me, there's not enough of me to go around.

How do you think, or do you, how do you decide how you're going to spread yourself out?
With the kids, it mostly goes on behavior, their behavior. You know, I just take it as it comes along, wherever I see that they need me. That's the only way that I know.
What about how you spread out yourself with your own life and with your kids? Do you know what I mean?
Ya, I think I know what you mean. It's a very fine line. Because I think maybe that is why I'm having all these problems because I want more for myself and I don't have time for that because of my kids. You know? But I am managing to do both, going to school - this is something that I really want to do for myself. I do what I have to keep both going. I am supposed to be there when they [children] need me, but when I need something, I don't get anything. Maybe that is selfish in a way, but it's bothering me to be honest.
Do you think that has something to do with the age of your kids?
Ya maybe. Most likely. It's the older girls that really bother me. Just laying around not doing anything. Like when I was so sick, I'm crawling around at home trying to feed them, and they won't do anything. That really bothers me. So I guess their age has alot to do with it. The way they think, the way their friends think, that influences our lives at home.
That in turn, does that influence your health?
More and more. I am finding that. Like when Jan was going through the stage that Jill is right now when she know everything, she's got to prove me wrong one way or another. Uhm, I figured good, she's going on eighteen now and she's pretty much on her own now, she has to take care of herself because I won't do it anymore, I can't. And she's doing alright. Then I think about Jill, I have to treat her differently because I can't use the same things that I did with Jan to get her to this point.
I get the feeling that your kids and how you interact with them is a big part of your life.
It's the main part actually. Because for myself, the things that I do for myself are very little. I plan to make more time for myself, the things that I want to do, but then I get this guilt set in. You know it's hard to get rid of that. I have too many responsibilities as a mother to my kids and I can't, I have a hard time with making out the difference. Where my needs are not as important as theirs.
And how does that tie in with your, how you see health? Where is the interface or the influence?
Let's see [pause]. All I know is that my kids are so much a part of me, my lifestyle and everything that goes on that. Like, it's obvious that what goes on with them is a part of my happiness to me, my health. And I have alot to do with they way they are, their health. Health aspects and what not. I've been wondering lately if the reason that I have been so sick lately is the stress problem that I have had to deal with the kids and myself. Like being in school and having to differentiate, like being in school then coming home and being at home again. Changing gears all the time. And with all the different kids, I think that it has alot to do with my illnesses, mostly the asthma. I notice that when I have a hard time with my kids, like arguing or anything, or even feeling neglected from them, I start to get choked up. It really bothers me.
I'm thinking about how you would define yourself. Because motherhood is such a big part of who you are. Are there other parts? If we had never met before, how would you describe yourself?
Earnest is one of the things. Adaptable was one of the things. I find that I'm really good at that. I used to think that I was really quiet, but not so much anymore.
Can we go back to adaptable? Where do you think that ability to be adaptable comes from?

Uhm. I don't know. I think that I have had to make so many changes in my life, like that I have had to think differently about changing attitudes and changing thoughts and ideas about things, people. Uhm, like for instance, going to school, I was the only Native at school. And at first I didn't recognize that as a problem, and then I found out it was a problem. So I had to try and be like everyone else at school. I think, different situations have made me learn to be adaptable. You know, when I was married, responsibilities that I had to take on there was part of it.

Can you talk more about when you were in school and being the only Native person?

Up to Grade 5, I was the only Native person. I had a hard time. Being called names. My parents were Native, but I grew up in town. I wasn't on the reserve or any strong Native or cultural values at home. My mom spoke her language once in a while when my grandmother was around. And when I was in school I had white friends and Native friends. I knew that I was Native but I didn't realize how much criticism I could get from that. How much harassment. Which I did, like I said, kids can be mean. And I worked really hard to be as smart as the top person in our class. I got good grades, until I got to my teen years where I already knew everything. There was quite alot of prejudice, overt prejudice. Some was a little more subtle. High school wasn't too bad for prejudice and all that. We had our own little group, there was five of us. One of the girls wasn't Indian but she acted Indian, she was like the rest of us.

How did she act Indian?

Well I mean, she wasn't snotty, she wasn't better than us because she was White. She was like, a part of us. I have worked at not being bitter about all that business that went on, like it's done, what am I going to do now to change it. I was going to teach my kids a little bit of fairness, you know. At one time I was going to teach my kids to be prejudice against White people [laughter] but I don't know what good that was going to do. Then they would be no better than the kids that called me down.

What does it mean now to be Native, where does that fit in with your life? Hum. *Or does it?*

Actually it does. I am finding a pride that I didn't have before [sighs]. Alot of it is through school here, the knowledge that I pick up and the things that I have seen through videos, through people. And the awareness that they have; they teach you the Native culture. I am finding it really interesting, and some of it is actually heart-breaking. Some of the things that have happened to Natives. When I was growing up the attitude that I was faced with was the Indians drink alot, that they don't know how to look after their kids, that they are unclean. You know, all these bad things. But, uhm, now it's different. I find that they [children] are not as aware of being Indian as they are of their class, you know, like middle-class, lower class, they are more aware of that, they are paying more attention to that than their own culture or anything like that. So this is kind of opening it up for them.

One of the things that I was thinking about because I re-read some of the interviews, was how you define stress. Because stress is something that comes up again over and over in terms of health and how people view themselves.

Uh, well I know for myself if I'm stressed it's when things don't go right, what I see as being right. I guess it's worry. I worry and that causes me, causes stress. I worry about the kids doing this, or going that way, or their lives, their futures, you know, what's going to happen. And worry, worry about trying to make things happen the way I see that they should. You know, that's stressful to me.

And how does that stress tie in with how you think about health or how you feel about yourself?

The way I see it, it affects my health because worrying is like a tension, I don't look after myself properly and I end up getting run down. You know, then I start having side effects, like I get sick easy. If I get a cold, I end up with an asthma attack, and then I get a chest infection and it keeps getting worse and worse, and it's all from stress. When I worry I don't look after myself properly. And the worries bring it down to the health. Where my body breaks down.

So you have had lots of health issues lately.

Ya, alot. All this, actually I was sitting thinking about it a while ago, I've put alot of it, I ignore alot of the signs, you know, body wise, physically. I ignore alot of the signs.

Do you know why that is?

Maybe they will go away? [laughter]. I don't know, I think alot of mind over matter, I still think in those terms. If I keep myself occupied and I don't worry. Like I'll take care of it, you know, if I need an antibiotic I'll go take care of that, but I don't dwell on it. I try not to, because I think, in my mind I will end up even worse if I dwell on it too much. If I start babying myself too much I will start getting worse.

Where do you think that comes from?

I don't know, I've never thought of that. That's a hard question [laughter]. I really don't know. I think maybe the way my mind works I guess. Now you've got me thinking about something else [laughter].

Well tonight when you're laying in bed, you can analyze this. It's good to hear you laugh, you probably need to be doing more of that.

Ya, like I was sitting there talking to the doctor, he asked me what I do as far as spare time. Spare time? Lately I have bee: home alot, and I think that's what really has gotten me. Because I'm the kind of person that is going and doing, doing all the time, whether it's going to visit someone or take the kids to the park, you know, going somewhere, doing something. I don't have a vehicle and it's hard for me financially, to get all the kids on the bus for one trip it's going to cost me ten dollars, on a bus, and twenty in a cab. And I don't have that kind of money [sighs]. I think that has gotten me down alot, that's bothered me alot.

So, how do you feel about yourself, how does that fit in with that picture of health? Maybe I've asked that question before. Like staying at home, not having a car, is that self esteem or is that, uhm, mental state or what.

Ya, it ties in with self-esteem, I can see it with that because I'm not uh, fulfilled. Because I have left so much out, and uh, like being home, the way I describe it is being stuck at home. You know, you're stuck at home.

And does that fit in with that concept of balance?

Ya, alot to me. As far as, like, I know what I have to do at home, the main things, I get it done, like the housework, I feed my kids, I do all that I have to do at home. But I need something for myself. I've got school, there's certain things that you have to do and uh, to me I've been out of balance because I haven't been able to do the things that I want with my family. So my home life is a little bit out of balance because, you know, I guess it's the way I think about what balanced is like.

What would be the perfect balance, what would be that ideal for you?

Uhm, the perfect day, get up and go to school, the kids do their own breakfast and, you know, we all eat breakfast, the regular picture of family. And go to school and come home, and the kids would be, I don't know, that we'd all have our own little things to do, our own time, and then we'd have our time together. The last couple of days I have been trying to figure out what I can do for myself. I'm just wondering if that's what keeps pushing me, keeps me pushing all the time, doing all these extra things. I always seem to push myself. And maybe

that's what I'm looking for is that little time by myself, because I always feel like I'm looking for something, reaching, and I push myself to a point of self-satisfaction and I can't get there.
Is that an end? Is that an end goal or is that something that we always work towards?
I think it's something that we always work towards, but uh, ya, something that you always work towards but there's always something farther that you want. Like you can set a goal and then you can see something past that. That's what I do, I push, I find. I can go a little further, further.
And is that what self-satisfaction is, what you want and what you're looking for.
Ya, what I'm looking for. I don't really know, I haven't really set it down in terms of goals, I just keep pushing and going around in circles, and maybe that's what it is.
That's one of the things that I have heard with the interviews with health, it's not a thing that you can get to, it's a process with ups and downs. Could you related to that?
Ya, alot of downs. Ya, I guess that I could relate to that because it seems like an endless cycle almost.
And then the choices that you make around that influences that process of health or self-satisfaction.
Ya, very much so. Like the way I see things, the choices that I've made, I don't know if I'm satisfied with that. I mean there's no, nothing could change the choices that I've made so far but it influences what I'm going to do next, like this surgery. Like health wise, up to now I've been putting it off and now it's gotten to the point where I could be in big trouble, you know. But, like now, I guess I am kind of like that in alot of things. I push myself to the point where I can't, I have to make some real major decisions.
And are you pushing yourself to that point where it gets to the point where you're kind of like in a crisis?
Ya, almost in a crisis, ya. To where I'm at the edge and I have to make a decision one way or another or until the decision is made for me almost.
[*After reviewing initial themes from interviews with Margaret, she responds*]
And it all boils down to that my body reacts to all of these things, all put together. Let's see. What was the last one.
Activities, energy.
I was just thinking about that exercise. Like I've gained thirty five, almost forty pounds since Christmas. And I, at the start I quit smoking, I will gain a little weight, I'm depressed I will gain a little more weight [laughter], I love chocolate, I'll gain more weight [laughter]. Anyway, I have gained so much weight I have started to feel really disgusted with myself, I have to get myself down again. You know, like, I have in my mind that since I gained weight I have become down on myself, I have had alot more health problems like with the asthma, and I am lazy, I just get lazy when I get bigger, fatter. And I just don't want to do nothing, you know, and I figure that's probably half the reason for the depression right there.

Janice

So, I will throw out the question, what does health mean to you. You said that you have been thinking about the meaning of health.
Ya, I have been because I can hear health, and I can think of it as, okay, these aren't too different but I can look at health and say that it means eating right and getting exercise, you know, feeling good about yourself, and health can mean just your mental being - you know, how you feel about your self. Like maybe I'm overweight or whatever, it's how you feel about yourself. And your physical, going along with it, is your health. Like I have asthma.
OK, so the fact that you have asthma, how would you say that it influences your perception of

health?
I look, I know, I know that I would be better, my asthma wouldn't bother me as much if I were exercising more. I don't exercise. Except that I go for a walk here and there, I don't exercise as much as I would like to. And I know that I would feel better if I did. So actually today I am working on that, I just signed up at a gym. Before kids I worked out, and I was actually playing sports alot. And so I got to the point, you know, my asthma wasn't really, it isn't a really big thing but I still feel that uhm, at the age I am, it is deteriorating a fair bit.
I was just thinking of health experiences. Have you had experiences that have kind of stuck out for you in terms of health?
[Pause].
Either for you or family members.
I guess I do look at health as physical health. I know from when I was little, I was sick alot, I had a tracheotomy, bronchitis, double pneumonia, my parents smoked all the time so I blame them for my asthma [laughter]. With my dad, he had a stroke when I was in high school and that was a big part - I really looked up to my dad. He was an independent person that worked his whole life. And traditional, to have mom home looking after the kids and he worked. This happened just after he was retired. He wasn't sixty-five yet. The place where he worked retired him before. It made it really hard in the house. Uhm, his left side was paralyzed and you know, it got to that point from feeling that he failed somehow to us, or himself because he knew that he could still carry on working, but it was just being home, not knowing what to do with himself. The stress you know. And from then he had another stroke. I was alot younger, now I look at him and think, if I was older I would have helped my dad. When I look at things now, the fact that it was very hard on my mom and dad and uhm, from there he's had couple of strokes after [pause].
Downhill from there?
Ya. Now he's in a home. And that's even harder [sigh]. It was a hard decision for my mom to put him there, in a home, she just didn't want him there at all. She didn't want to put him in there, but she couldn't look after him either. She has diabetes, and she has had that for years and it's hard, she's not one to look after herself that well. You know, so his Alzheimer's started coming on a couple of years ago. But I know I have to look at it that it's best of him there because it was wearing mom down alot more, having him at home. So, she knows he has to be there too. She doesn't drive so it's hard for her because she can't go and see him as much as she would like to.
So are you involved with having to do some driving and things too? Ya. *That makes it difficult for you too.*
I only have so many hours that I can spend with my immediate family before the kids have to be in bed and stuff. If I'm out all the time, it seems, that I build up more stress or guilty feelings. I think that affects health. You know, stress. I feel anyway, that your body gets run down, you worry and think about things so much that you forget about yourself and then it catches up with you, in the way of getting sick or [pause].
So mental and physical. Other components to health?
Well, you could look at your spiritual. Hum, let me think about that one [laughter]. Well I guess that if I were to say spiritual health, for myself I would be thinking - when I think of spiritual, I think of what my beliefs are, what I believe in. Alot of what I believe is, working and going to the Centre, was alot of the circle, for a whole. And those were our components of the circle - spiritual, mental, emotional, and physical. If one of those are out of balance,

then you will find that, there will be, not an uproar in your life, but some type of, I can't even

think of the word. Your life would be [pause].
Chaotic?
Ya. Chaos. Your life wouldn't be as smooth as if you have all parts on an equal level and they are all balancing each other out. For myself, I look at the physical component that's why I feel down about myself. So, that is the component that I need, for myself.
I asked you before about the connection between health and healing. Uhm, what else can you tell me about that. If there is one.
OK. For myself, I feel that there is a connection for me. I feel that if I feel better about myself in physical and mental parts, that would actually be part of the healing that would take for my mental to be good. They tie in together, I can really relate to the fact that when you're healing and working on all the personal issues that have happened to you, if you need; some of it can be anger and if you release all that anger that is one way of healing but you still need to be able to let it go - and that can be in walking, you know, exercising or swimming or whatever. I feel that they are connected that way. And for alot of people their healing is part of doing healthy things - eating right, exercising.
Do you think that beliefs are passed on, and if so how?
Ya, I do believe that beliefs are passed on, you know, being raised by my mom and dad, they have alot of beliefs that actually I see now I use now at times, and I have to catch myself [laughter].
Can you talk about some of those?
Well, just like superstitious thin[illegible] maybe, and with another beliefs. I guess why I always question too is because my mon[illegible]d dad were Catholic and I was raised Catholic. She didn't like, or approve I should say, of [illegible] going to a different church because she believes that if you leave your religion that you [illegible] pay for it, not pay for it, but in the end when you are on your death bed that, uhm, she really believes that. But it wasn't anything about the cultural things. Like now when I talk about sweat lodges and things, she believes in them, she actually has taken part in them, because she has diabetes and was sick for quite a while, about ten years ago. She had went to Alberta to see a medicine man, I guess you could say, and had been through the sweats with them and actually it did help her.
Did she talk about why she sought out a medicine man?
I guess that's one thing that my family believes in. My great grandmother had also thought that the right type of medicine man could help you with what you were needing help with, whether it was health or. But they had also stressed that there is bad medicine.
And do you know about good medicine and bad medicine?
I really don't know alot about it, just the stories that I hear that are passed on. Even hearing these stories and not knowing if they are a hundred percent true makes you wonder if it's really true [laughter].
So how does that fit in with your belief system?
Well, I don't base any of my judgement on it, I guess. It's in my mind, I think about it and I wonder but I don't know enough about it to really to say "yet it is" or "no it isn't". So, it's there. I do at times, uhm, at times when I am thinking about something it gets kind of scary when I think about it.
What about your beliefs about the circle and the four components to the circle.
Actually, you know, I didn't know that much about it until I started here. And to hear people talking about it I was still really confused. It just didn't make sense until the last while when you hear about the four - emotional, physical, mental and spiritual. It makes sense. If you have one of these out of balance, you have something, not really a ruckus, but something. Actually I look at that alot in terms of that I know for myself that if I'm not doing something

for myself, play or fun, I get really stressful and I get to the point where I am grouchy.
I think that what you just touched on was trying to get that balance, or it is something that is constantly in flux or [pause].
I'd have to say that with the balance, like sure it is always happening on it's own, the things that you do with the four components, but you have to make sure that you do, that you are getting them because it's so easy to work, work-work-work and family and you can throw yourself into that so much that you forget the rest. And you don't realize actually, what you're missing, what your body needs or whatever. So you do have to, you know, you do have to do a check in order to keep the balance.
It's amazing how things kind of take control of your life though, like the car thing [shopping for a new car].
It's kind of pushed everything else, it has, it really has. I have really noticed it these last four days. I'm edgy, I'm getting impatient, I'm, you know. And I have had to think is this something that I want to do, maybe this is a sign telling me that I shouldn't just jump in and get this vehicle. So, you know, I look at it like that. I guess that would fit in somewheres with beliefs. Beliefs to, if it's not falling along smoothly then think about it more before making a decision. And if I look at that as in health, yes, I push that aside when it comes to work, and with the kids, and house stuff and you know, family things. And so I tend to, with my own being, I tend to, with my medication even I don't take it as much as I am supposed to, I put it back. For the things that I would want to do to be healthy, as in exercising, oh ya, I have put that off for years. You know, procrastination is a big part of me, it is. I wait until the last minute for things, I know. So I've got to try to, within myself, remember that I'm like that and so that I can work on it, and change it.
What about with your health? Have there been situations where you have procrastinated and that has gotten you into "trouble"?
Well, I guess it would be more with my asthma. You know, my doctor cautions me, "if you don't take your medicine" or, and then, sometimes I think, I don't know, I am a little bit leery about the medicine also. I know a doctor is a doctor, but sometimes I think "well what is this medication doing to me really?" Maybe it's going to make it worse and so, and then at times I say that it's not that bad I don't really have to take it that much. You know he wants me to take it four times a day, *your puffers*, and I take it maybe once a day, sometimes I am good for four times a week [laughter]. So I, I don't know.
There's a couple of other things that came up that I wanted to talk a little bit more about. One of them was when you were talking about your mom with diabetes. The question that I had reading through this is whether you think your mom is healthy.
Do I think she's healthy? Actually, no I don't.
OK, so why not?
OK, now I am looking at the health as, for her, in a physical sense in that she has emphysema, she doesn't follow a diet that she's supposed to for her diabetes and that gets her sick every now and then. She's had to go, the emergency has had to come and get her a few times and uhm, she, I feel that, she does keep up with her medication and that, but uhm, I don't feel that she's all that, she's not as healthy as she could be. I don't know if that part of that is what happened with my dad and she let herself go so much. She did that when her mom died; she was very close with her mom. And when she died, that is when it seemed that she let go of herself, she didn't really watch. And I notice in the things that she does too. Before when my granny was alive, and dad was working then, she was always cooking and she was an excellent cook - a wonderful baker. She was always doing that. And then after what happened with my granny and what happened with dad, his stroke, she's down lots. She

barely, she will maybe eat once or twice a day. She, her house, you can even see it - she doesn't look after it as much.
So you wouldn't consider your mom healthy, would you consider her unhealthy, sick?
I would say unhealthy.
Is that different than being sick?
Hum. I guess I look at is unhealthy, sick. I guess it would be for me, I would be looking at it as the same. Her memory and everything is fine, her hearing is bad and she won't get a hearing aide and she can't see very good and she won't get glasses.
Where would illness fit in into that picture of health, unhealthy, sick.
I don't see any difference.
So the terms that you would use to define your mother are unhealthy, sick, ill?
If I am looking at the physical, ya.
The physical dimension. Is there a point where the physical part over-rules all the other so that therefore you become sick? Or can you be healthy in one piece.
Like now-a-days you say things, you say words and you don't really think of what the real meaning of it is. So you are used to people saying "oh, he's sick" or unhealthy. To me it means the same. I'm not looking at it as yes, there could be someone with diabetes that is healthy and fit, that is what I think health is, being able to do, activities and stuff. For my mom, looking at her now, uhm, she really can't do too much. She can't even to go outside in the cold with her emphysema and her diabetes. She's coughing. I just don't see her "in health" in the physical sense. Mentally, certainly she still, her diabetes has affected her in maybe ways that she feels about herself, how she thinks about herself. She doesn't really make any judgements on the things that she does because of her diabetes. I don't know if that answers your question, but [laughter]. That's a hard question, for me it is.
[*Discussion about beliefs, church, and good/bad*]. *How do you decide what is good and bad then?*
What's in your self. You get a feeling or whether you should, I do, I can't say you do. I get a feeling inside myself and I know that something that I am doing is wrong or whatever and I can make the judgement on it. I guess that's what I like, I mean, nobody is going to know for each other what's good and bad for them, you know, you've got to know that yourself.
So what is good for me might not be good for you?
Right. I feel anyways. But everybody's different.
Does that apply to health do you think?
Yup. Yup, I think so. Within that sense people get doing things for themselves, other people have to do other things. And I feel that for me to feel healthy, healthier about myself, I have to know what has to be done for me. No one can tell me, "you have to do that". You know, I've got to know, like with my weight.
That's something that you've brought up several times in terms of weight. I don't see you as being an overweight person.
Ya, I guess that, it's always been, like what I said before about having always to please other people, that has always been with me through high school. I am one person that if someone has made a remark about what I look like it sticks with me. So, but [pause], I don't know why I'm stuck on this weight thing. It bothers me though.
There's a couple of areas that I want to get some information about before we get into the themes. The first one is balance, how would you define what balance means?
Balance, well, let's see. Depending on what, I guess, balance is just having an equal, for me, I guess I would have to think about what are you relating it to.
OK, so balance in terms of how, people are using balance in relation to health, and that they

are seeking this balance between the four dimensions of self. So, what would that balance be for you then.
I guess, if you are talking the four dimensions of emotional, spiritual, physical and mental, then a balance would be having each one of those, something out of each one of those things part of my life.
Uhm, when you think of all those things and apply that to your own life, would you say that it's balanced?
No. I think for myself I would, the spiritual isn't a big a part of my life as I would like. I think that I'm missing something on that that I would like to do, so, and physical, well, I'm doing things, there could always be more there. But basically with mental, physical am happy. Actually I seek counselling and I attend a woman's group and so I am able to deal with my feelings and emotions and that. I guess that would be, right now, I think that in my life right now I feel like I'm at a standstill sort of, in the mental area that, when I think of mental I think of things that I could be doing for myself. Maybe not training, but that would be part of it. To exceed further in my career, and so that's kind of at a standstill right now. It's been on my mind quite a bit actually.
OK. And what about stress. What are the limits of stress, what are the, what causes stress. I am trying to get some picture of what stress looks like.
Well, for me stress would be having to be two places at once [laughter]. Yesterday I was a little stressed. My husband had asked me to bring supper out to him at the property by, he was hoping by about five thirty-ish, my two boys had ball - one at one end of town, the other at the other end of town, both at the same time. And they're only seven and five, so, and then I was out to drive out there and I was just [clenches teeth and shaking head], that was stress [laughter].
So the things that cause stress, the things on the outside are: the element of time, the fact that you have to do too many things. At once, yes.
[*After reviewing the initial themes from interviews Janice responds*]
Like when I think of, like when I hear health I think of more of the exercising, dieting type of words, so when you say these other words, until I hear you, how you're thinking about them, then I can see how it fits in with health. And actually after hearing your definitions on them too, I think that health is all of that. It is your life, you, what you do.
Would you agree with my, uhm, wording that health is a process, or would you see that health is more an outcome, that you "get to health."
No, it is, the things that you do affect the choices that you make and it takes time, like you learn it, and then it happens. Like, it's not that, well, you've set, well, OK. If you're going to say that it's an outcome, right, uhm, it's not that I'm going to go to my, I'm in a bad situation, uhm, I'm trying to think of an easier way to say it. That I'm going to go to my counsellor and that I will be better. I have come to realize that there are things that I have kept in and that I want to work on. And I go to my counsellor and I work on those things, and uhm, I still, she's not going to make me better. I still need to work on those things myself, and it may take time, and I still might not be better twenty years down the road, but certain things I will feel better about, within myself.
And so that "being better", there's an element of time and an element of work.
Oh ya, definitely. And it could affect all of this stuff at some point in my life.
OK, the other question, and probably the last data collecting question that I have is on here is, the influence of alcohol in your life. Not necessarily your own alcohol issues, but how alcohol has influenced self-esteem, or, like growing up in an alcoholic family, being in an

alcoholic relationship. Is that something you can talk about?
Oh ya, for sure, I can talk about it. Like, I did grow up in an alcoholic family for the first twelve years of my life and uhm, my self-esteem, yes, it was really low. That would have been one of the reasons that I was so quiet in high school and withdrawn into myself. I guess in the first part of my relationship too. And even now, being in an alcoholic relationship has, I guess the first part has kept me, my self esteem low, has held me back from things that I wanted to accomplish, and now that work has been done on it, it's still in my mind. I guess that's were the unstability comes from in our relationship because, I don't know, now I have grown so much within myself, I've had this realization of who I am and what I want. My self-esteem has picked up alot from where it was for sure. But that instability is still there. And that's still a factor to me, and I don't like that feeling at all. So it has, the alcohol has affected, me, for myself, I would say a fair amount. Because I know there are things that I wanted to do that I held myself back from. Even things, physical things that I had enjoyed doing.
How does that fit in with alcohol?
Because there were things that I enjoyed doing, sports and stuff. My husband and the drinking, I couldn't, I don't know, I couldn't depend on him to look after the kids when I was gone, so I wouldn't do that.
So you give that up, and what happens is your role as mother becomes more paramount in your responsibilities than your role as team player on a net ball team.
Ya, exactly. Right, exactly. So you know, that would happen. So now things have changed in our relationship.

Jody

So the first question that I am going to start with is to ask you what you think that health means to you.
[silence].
When you think of health, what comes to mind?
Individual's well-being. How they take care of themselves, how they eat, their physical. Uhm, I don't know.
Would you consider yourself healthy? [shakes head, no]. *No, ok, tell me about that.*
Cuz I haven't been eating the proper food that I am supposed to, that I know I should be eating. Just not in shape.
So eating and exercising - are there other things that make you unhealthy?
Like I smoke, I feel that that is really unhealthy [long pause].
If you think about someone that you think is healthy, could you describe that person?
An active, energetic person is what I see health is.
OK, maybe we'll go back a step. What would you tell me about your life?
I was raised out on reserve until I was eighteen, then I have been living in town.
Was that hard, moving to town? Ya. *What was hard about it?*
The transitions. Like moving from a small community where everyone was kind of together and then moving to town where I didn't know anyone. Change your way of living.
What was different about the "living"?
I was brought up on wild meat, and everything - eating healthy like potatoes, things like that. Not all the store bought things. Vegetables, everything like that.
So how did you learn about store bought things?
Uhm, I stayed with someone, white people for a while - I was a boarder.
I am really interested in you going into a white family and being part of that family. What

was that like?
It was really hard you know. Like with the routines, they had routines all the time. Like with us, it was suppertime when you get around to it; there's no set time. And you could count on it that at 1200 you would be sitting down at the table eating lunch, soup and sandwich and before it was like whatever. The food, that all changed for me. And TV, all that stuff, we never had all that.
How did you feel being a Native person in a White family?
Where I was I was treated very good, plus I had older people that lived a few blocks away so if I wanted deer meat or whatever, I would just go over there and have it over there. I was very close to those two as I was growing up, I stayed with them. So I had a bit of both I guess.
What made you move from reserve into town?
For me it was uhm, there was so much happening with alcohol and that, I had to get away from that. Plus having a child at a very young age [17 years old], he ended up getting sick and I moved into town and I didn't go back.
So your baby was sick? Can you tell me what was going on with him?
He had a kidney failure when he was a day short of his first birthday. He had to go to Vancouver for all that, and every year since. A couple of years ago it quit. Every year we would have to go back.
Can you talk about some of the experiences that you had as a mom with a sick child?
Again, not knowing what was going on, not knowing the terminology that the doctors use and. Being in the hospital and watching kids being tied up, that was really hard. Again I go back to the people that I was staying with; they were part of my life then and they still are. They have helped raise my older son. I drank quite a bit when he was a baby; they took him then. Today he is still part of their family.
So they basically raised him from a baby? Yup. *How do you feel about that?*
I have different feelings. Sometimes I feel really abandoned by him because he goes to them more that he comes to me, but they've got the money and you know. They give him what he needs, whereas I can't being a single parent.
You're a single parent?
We were broken up, most of the time that is how it's been.
Were you back together for a while?
Well we still are, now, but the whole thing - I'm still like a single parent. I'm more of a parent to him than...*In terms of who is responsible for the kids?* Ya. He's another kid. Another added responsibility.
How does your family influence your health or do they?
I think it does. Like if you're on good terms. I find myself, not getting sick and stuff. If I have alot of things on my mind, what is happening at home I get sick more, cold or whatever.
One of the things that we had started to talk a little about was the experiences that you had when your son was sick, and I know that you also have had some health "problems." Can you talk about some of those experiences? Tell me as much about them as you can.
I don't know. Like with my son when he was sick I was in Vancouver, if it wasn't for those people that I was talking about, probably I never would have made it. Being in the city, all by yourself and I was young, about seventeen. Without knowing anyone, that was hard. And to watch your son, he had to be tied up all the time so that he didn't pull out any of his tubes, twenty-four hours a day. And I spent most of my time there with him. I sometimes would take a rest.

What about you, have you had experiences with health care providers, with doctors and nurses.
Uhm, myself I ended up with a good doctor, the one that took care of my son, I ended up sticking with him until I moved over this way, but I have had alot of really bad experiences with other doctors who wasn't taking care of us, us Natives. For instance, my mother, she always had alot of pain in her stomach and stuff and she went in to get it checked out and he just gave her some medication and told her to go home. And finally, I took her in and to see what was wrong with her. And to find out that she had cancer. It was too far, you know, beyond that they could do nothing. And now a days, when my dad goes to the doctor I am usually there with him. But now that he's over there and I'm here that doesn't happen.
So how is it different when you're there, like when you go in to the doctor with your dad how would that be different that your dad just going by himself.
Cuz I know that my dad wouldn't be telling him exactly what was wrong and probably be misunderstood alot of times because my dad is not that fluent. So he won't ask questions or get an answer. And even if he does get an answer, he wouldn't have understood it. Were as if I am there, I act as an interpreter. I ask him questions before we go in and I like, you know.
What about experiences for you with health care professionals?
I think that I have had pretty good responses. Especially having a good doctor; he always made time for me instead of like come in and do things quick, he always had the time with it. Like there were times that I just needed the emotional support or whatever, and to talk, and he was there. I know alot of doctors wouldn't do that.
And is that the difference for you between a good doctor and another kind of doctor? Is the time element and the fact that he listens to you? Yup. *Have you been hospitalized before? I guess you had been in for your babies.*
Ya that and I had numerous kidney infections with my pregnancies.
What about some of those experiences in the hospital?
One instance I was brought here, I hated it. I didn't know no body. You're in a room by yourself and, like.
And you were away from your family. Yup. *Would you have considered yourself "not in health" then?*
Ya. I was under the care of a doctor, I don't know I wasn't feeling well.
So not feeling well to you means unhealthy? Ya. *Where would you put into the picture things like sickness, illness? Where is the dividing line or are they all the same thing?*
For me it is.
It's just the opposite of health?
Ya, if your not healthy then you are sick, or unhealthy.
And how you feel is health? Ya. *So not feeling right is unhealthy. Would you consider yourself unhealthy this morning?* Yes [laughter]. I was in tears actually. To be able to make a decision, like I really want a decision to be made this morning but I didn't know how to go about it because I am in a very unhealthy relationship. Like I don't have, I don't know how to describe it. Like I don't have any control. Like I can't make my own decision and carry it through. Like I have made a decision and now...
So there's more to health than physical?
It's how your mind works too. Like I was totally, I sat there with two math questions all morning and I couldn't concentrate. Like I know that I can do it, but I just couldn't do it.
[And later, continuing the discourse about her husband...]
Well, I thought things were getting better, like he [husband] went for treatment. He was

dismissed as he wasn't being truthful about all the things that were happening. I just found out, I'm just finding out in pieces that he's going to the extreme of compulsive lying. So I am just really angry [light laughter].
So now what are you going to do?
Kick him out. But how and when I don't know. That's the toughest part. I thought of everything. I've done this part to down here, and now that I am down here I don't know where else to go [gestures a line with her at one end then the other], you know. Like I am running out of things.
Do you think that's ties in with your health [relationship with husband]?
Yup. I feel, I have headaches, these really bad headaches, and I get my stomach pains back. I think that it is because of all the tension, and all the stuff that is happening right now. Two weeks ago, you know, I was fine. I had no headaches, I never even had to take a pill for anything.
Now that cycle is starting up again.
Ya, it's starting up again.
So how do you deal with that?
With my tension and stuff? *Ya.* I have been reading. Doing some reading because then I can be alone to, I don't have to deal with it.
Are you reading recreationally, or reading about other things.
Right now I am reading a book called "How to Bail Out", of a relationship. I was at the library and I needed something to read, and there this was.
What's it telling you?
All the stuff that I already know. And it reinforces some of the stuff that I have been avoiding.
I've got a whole list of things that I wanted to ask you today [laughter]. Uhm, cuz what I did is I have gone through some of the transcripts. One of the things that I am interested in, is how you would describe your life. I am trying to get a picture of your life.
Well it's been like, there has been alot of good times, and alot of heartaches too. With the relationships that I have been in, it's been up and down. You leave that one because it's not suitable. It gets to, like I have been in alot of violent relationships, so you leave that one for another one, and then a year down the road you find out it's the same thing. Like I said, like before I would never live with a man that would beat me up or whatever because I lived with that all my life with my parents [remains tearful].
How do you think that influenced your life, that you grew up in a house where there was alcohol and abuse, looking back on that? Do you want to take a break?
Well we grew up in a place with alot of uncertainty. Just like I am now. Like you are walking on egg-shells, not knowing what will happen. You always have to watch what you say. The same as I am going through now.
And your certainty is your kids, and school right? Yup. *Where do your kids fit into the picture in terms of how you feel about yourself?*
I don't know. They are really important in my life. I try my best with them, but sometimes I can't give them everything that they want. And it's been very difficult.
Are they your glue, are they what holds you together?
[nods head]. Ya. They do keep me together. There are many times that I could have turned to the bottle or whatever, and then I look at them.
And those years of sobriety are adding up hey? That in itself is cause for celebration. The other thing that I was thinking about is, some other people have used the word healing. Do

you have your own definition of what that means?
Healing. I don't know. To look after oneself. One's mental, physical, all those things.
When you look at yourself, what would working on healing be for you?
For me, like, working on areas that are bothering me, that's keeping me, that's within me that has to come out in order for me to go on. Go on with life. Cuz I have taken alot of steps up to, like from where I was, say even ten years ago.
So do you think that there's a relationship between health and healing?
Ya. I don't know. Like in order to have good health, like you have to deal with all those things that are bugging you. I know for me, like, what I am going through now. I haven't cried for a long time now.
Probably not since you last talked to me [laughter].
We seem to set these things up just at the right time.
Just when you need a good cry. I think that's good [laughter].
Somebody must be looking after me [pause].
[And in talking about learning, teachings, grandparents I raise the topic of good/bad medicine]
I am trying to think of which way you are talking about it [laughter].
I don't know. Those are terms that have come up with other people, and I am wondering what you can tell me about that.
There's, I guess you could say that some people use their natural power, or their, I don't know how you put it.
Are you wanting to put a Carrier word in there?
Yup. I know what I want to say. It's a thing that, some people use it in a bad way and they use it against people, and there's people who use it in a good way to help people. Some people use it to their advantage when they take money for it, and other use it for, just to help.
As their gift.
That's the word, as their gift. [Relates a personal example of bad medicine]. Grandma used to always talk about things like that, like that what goes around comes around type-thing. Well I have heard people talk about it, different things that they have had to go through. That was scary.
Now would you say that with your medical conditions, say your kidney infections, why is that happening?
Probably alot to do with imbalance. Like I have been under alot of stress and that, I find, it's got alot to do with all that. Like I let myself run down so much, I don't like eat some times, just coffee. It depends on what kind of mood that I'm in. The only good part of that is that I've lost a bit of weight. I was really fat, wearing size 32, 34 - 32 was too tight and 34 was just right. I came right down to size 27 or 28. That's how stressed out I was. I couldn't eat no matter how I tried.

Karen

We were talking about religion. One of the questions that I have is where you put in smudging, do you see that as being part of your faith, or [pause]?
Basically I use it for an opportunity to have one on one with my kids. To me the smudging cleanses me and that whatever the smoke doesn't cleanse on the outside, I bring out in talking. I feel more comfortable and relaxed. I can just sit there and say what I want. And our smudging is when all four of us as together. And we all listen to each other.
So you use that also as almost a talking circle opportunity. Ya. *How do your kids respond to that?*

Well, my son was always really sceptical about joining us, because I let it be them that wanted to do it. First it was just myself, then my seven year old was curious and wanted to join so she started. And then my nine year old eventually picked up the same curiosity and she started. And then I said well, we might as well do this properly rather than just me doing it in my room we will do it out in the living room at the dining room table. So that's were we do our smudges. They look forward to it. My son, one of the first questions I asked him when we wHere doing it, actually I asked each one of them, was why they want to smudge with me for the girls, and why he was sceptical about wanting to smudge with me. What was it that he felt intimidated by?

Was that something you just started recently or have you always done that?

I just started recently, in January. I started smudging because we were doing it here and I always felt good about it. And when I missed the smudges here I kind of felt like I missed that highlight of my week. So I started doing it at home. I had been given the stuff for smudging last summer by a medicine man but I never really thought too much about it then. And then now, I'm actually like, "oh, I need more sage."

How did you, I have lots of questions but my problem is putting them in the right words [laughter]. When you sought out the medicine man, how did you make the decision to do that?

I was just thinking about that because that's kind of beliefs and health. It was at a time in my life, it was actually a year ago this past Monday. I had lost my nephew, I went to Edmonton for the service and I came back and started, uhm, hallucinating, having weird things happening to me. It was really scary. I never, never ever thought about good medicine and bad medicine, evil people good people, I always thought like one in the same. People don't try and intentionally hurt you. So when I started getting these things happening to me, it was really, really scary and I had a hard time sleeping. I went to the pharmacy a couple of days later because I thought it would just stop. And my friends and family all knew about it, like all my closest friends. And one of my friends suggested me seeing this medicine woman that she had seen. So, my friend finally found this phone number for me and I called up this medicine woman and she told me to come up to her place. And so I went up there. When you see a medicine person you always bring them offerings of tobacco, pouches of tobacco.

Is that something that you always knew or did someone tell you that?

I knew from when I was small. Our smudges are different from sage and that when we are small, and I never quite thought of them as the same until quite recently.

What did you use when you were little?

The fungus growth on the tree, we use that. And that's one of the things that I don't have now [laughter].

OK, so you went to see this medicine woman and you took her an offering.

Ya, and she had another guy there with her that was learning and practicing. And they did this, we talked alot. And he put his hands on my shoulders, and asked me if I was nervous or scared and I told him, ya I was. And he told me "if you are thinking or nervous that I am going to do bad medicine on you, don't think like that because I'm not like that." And it was purely trust on my part that I had gone to see him, and my friend's referral. So when I went to see the medicine man I was like at my wits end, stressed out, and he gave me a feather, an eagle feather, and told me to pin it above my bed and it would protect me, my dreams, and that I would be safe with that. And I never did have those dreams again. So it really made me think, how effective was this.

Do you still have the feather there?

Ya, and I use the feather in my smudges to get my sage burning.

[We move on from this topic to talk about her family...]
I come from a family of five, four sisters and my mom, that's who I grew up with, our family unit. I have seven sisters and brothers, my dad is remarried, third time. I have a step-brother and two step-sisters.
So what is your relationship with those people, tell me about your family and tell me about you, as much you want to.
OK, my dad and I. Well, when we grew up, my mom was an alcoholic and my dad, my mom had, I'm not sure if it was six or eight years, it was between those years when I had last seen my dad. He had left. And then my life seemed to change after that.
After he had left?
Ya, cuz before we had a home and we had to pack our water, and alot of work but it seemed like to most peaceful time of our life, having to do all the menial chores [laughter]. A three mile walk to school was nothing for us.
[I seek clarification of living on-reserve and off-reserve].
I did live off reserve as well as on reserve. My dad's white, he's not Native at all, my mom's Native. After they went through the custody and that, my sister that is two years younger than me, we kind of had to share a room and do alot of things together. We kind of hated each other at the time but now we laugh at those moments [laughter]. We always seemed to be in each other's way.
So you're mom got custody of all you kids?
Ya, so she was raising five daughters. And mom turned to alcohol after that. But we grew up with her not wanting us to talk about our dad, to even say his name in the house was kind of like a taboo. We had no idea where he was but we kept hearing from relatives once in a while that they seen him in town and he was looking for her [wife]. Those were the times that we would get curious and ask these questions. And mom would get really physically violent with anyone that would ask, so we kind of learned to not ask.
That must have been hard though.
Ya. And it wasn't until I was fourteen again that I seen my dad. That was just because my cousin had died. We talked to mom saying that we have to go to the funeral, he is our cousin. Somehow or other we got mom to agree, she took the three older daughters and we went by bus. It was the first time we had seen dad again, and it was really different, posing for pictures with a guy you're not sure who he is but he's your dad.
And where do your kids come in, tell me about your kids, that period of time.
I got kicked out when I was fourteen, and I basically stayed with friends and family. And when I was fifteen I got shacked up, sixteen, I had my son a couple months before I was seventeen. One of the things that we never learned when we were growing up was anything about the birds and the bees.
Umhum. Can you talk about that period of time, when you were, kind of what brought up, the period of time coming up to when you got kicked out of home and then that transition to motherhood?
I started smoking, drugs, alcohol, when I was about thirteen. I got, ended up, choosing a boyfriend that was much older than myself and mom totally hated him and I don't know, she was really prejudiced against any of her daughters going out with any Native people, I don't know if she still hold the same belief today or not. And, that was another one of the factors in why she hated him.
Cuz he was Native? Ya. *She wanted you to be out with a White person.* Ya. I could never quite understand that one. And so she kicked me out because I was going out with a Native

person and told me if I figured I knew, had all the answers and knew everything that there was no sense in me being in the same home. She wasn't there before, so it wasn't any shock for me to have a different living environment. Actually felt more at ease I think. At home it felt like I was walking on glass. Every even we had when we were growing up, going out to the beach or to the lake, out for a picnic by a creek, whatever event we had, they were happy events but they always had alcohol involved [pause...].

And then you got pregnant.

Yup. I told my son today that everything that I learned about mothering was through him. I never even considered the topic, or anything about being pregnant before, or even asking questions about it. So, everything I learned about feeding, changing and burping a baby was all through him. he's four years older than my middle daughter so that, uhm, everything that I learn about puberty and stuff like that is through him as well [laughter].

So how did you make a living then, how did you survive?

How did I survive? By social assistance, and my ex, my son's dad worked and he was going to college that year as well.

Would you consider yourself poor at that time?

Financially I guess. It never really bothered me too much being without money and to this day if I have a buck or two bucks in my pocket it doesn't bother me, cuz I think that I have more than I had then. So I'm not really much on material, financial things, to me my being, my strength is more from inside. And that's one of my pet peeves is when people take material values as far, they value it far more than the spiritual values.

[*And in talking about her personal characteristics...*]

Honest, caring and trusting and it always seems to be taken advantage of.

Can you talk about some of that?

With trusting people, I trust them right off the bat, they don't have to do anything to make me feel that I can trust them. And it's when they do things that makes me wonder about them that I start loosing their trust, and I find that really hard to regain.

So you have had experiences where that trust has been eroded?

Ya. And not, by just about anyone. Not just my family, like there are things in my family, but I won't loan my sister money because I know she is with it and I can't trust her with loans. And, [pause...] I don't talk to my mom because it gets twisted out of proportion or stretched out and it's not what I said or not what I did. I will talk to her about other things besides what I am feeling because it gets too stretched out. And, I find the biggest trust I have with my family now is with my dad and part of that was because he wasn't there and because it wasn't of his own doing. And that he is trying to make amends with each one of his daughters and it finally happened this past Christmas. Now he's trying to find his son, looking for complete I guess.

Hum. [*We move on to talk about her present life...*]. *So what brought you here to the centre.*

To the Centre [pause]. A bunch of the programs that the Learning Centre offers were delivered to where I was working. And I went through them, and one appealed to me because I want to get, like working was fun, I enjoyed working there but I didn't care too much for office work but I enjoyed my co-workers there, but to me it was just a job and I wanted a career, not just a job. Something that is more secure, and this program offered it to me. I was a receptionist there and I didn't see myself being a receptionist forever and the pay there isn't something that I could get off social assistance and that is one of the things that I'm working on. And I don't see office work as doing that for me. So a career sounds like it's more secure and the pay will be better because you have a degree to back you up, with a degree, they have to pay you better.

Do you think that you're kids play a role in, I don't know, your desire to get off social assistance?
Yes, because I don't want them to think that social assistance is a way of life. I don't want them, I want then to know that they have to work at it and the sooner they do the less stressful for them as adults with families.
Ya. So would you consider yourself to be a single parent for most of this period of time, most of the thirteen years.
Ya. Even when I was shacked up I felt like a single parent because he was always working or just never there, like working in camp jobs and stuff like that.
How did you, I mean I'm not a mother so I find this quite amazing. How did you deal with it all, all the roles that you would have to play?
I think that basically I just accepted them, I thought of them as like this is the life I chose for myself, no one got me into this except myself and now I have to do my best in it. And if my best wasn't good enough, it was only because this was only what I knew.
Cuz you didn't have anything to go on. Right. *How do you find it now, juggling being a parent and being a full-time student?*
Stressful at times. I don't know. I have rules and guidelines for my kids and when they go visit their dad, he doesn't see them very often and he throws out the rules and the guidelines and lets them be the ones with the rules and guidelines. And when the kids come back to me they have these little attitudes about wanting the same thing this time, "well, dad lets us go to bed whenever we want to" [laughter]. Stuff like that I would have to deal with. And those are the times that I find stressful. And it's just basically trying to get the kids to understand that when it's their bedtime that that's my time when I get to do homework that I need to do for myself.
Hum. So where do you think that your kids fit in with your health, do you think they do?
With my health. I find that when my kids aren't at home and they're with their dad, I don't care about cooking, my place would be clean because I'm not messy and so I didn't have to worry about cleaning either. But I didn't cook when my kids weren't around. I would be doing more physical activities but I wouldn't be cooking at home. My coffee pot would be dirty [laughter], and I would just nibble on fruits and stuff.
So how would you, this is usually a hard question to answer but I will ask it anyway. How would you describe what health means? What does health mean to you?
Where you take everything that's happening in your life and you find a happy medium, the balance between your physical, mental and emotional, and your spirituality.
So it's finding the balance between those four things. What else can you tell me about that?
Well, if you're like physically fit but you're not meeting your emotional needs, when you feel that part of you is empty and that, then you kind of feel that you don't have that balance. And that's when, it's times like that when you would feel more stressed.
Where does stress fit in with the picture of health?
The little things and big things that happen in your life that make your lifestyles changing for a day or two, or weeks or months or the rest of your life, can add strain. And coming to accept them is probably one of the hardest things to do but it's probably the only thing you can do sometimes.
To accept those changes. Ya. *Are you thinking of something in particular?* [shakes her head, no]. *What about that balance between those four things, how do you get that?*
[pause...] Each one of them kind of coincides with each other. Like, uhm, you could have a bit of your spiritual beliefs and your emotional needs, they would all go together, you would

have to have emotions about what you feel about your spiritual beliefs. And your physical too, your spiritual, smudging is something that you do physically, you can have your emotions with that. So it all coincides.

If something is not in balance, what does that do? If those four things aren't kind of in balance?

It kind of throws every other part of your life out of balance, it seems like something flips over.

And how do you get back to that balance?

Right now I find it really hard for myself to get back in balance. Nothing, because of all my emotional needs in myself that I find it hard to deal with and it just makes it hard to balance it [tearful].

So I will switch topics a little bit. How would you describe healing, that's a word that you used before.

Healing. I guess it's what I do with my dad, when we talk about what's underlying for you, like what's bothering you and talk, deal with it and it's done with. Just talking about it seems to help. Maybe something will come out of it, and you have to dig deeper, find out more about it.

Where does healing fit in with your life?

[pause]. Where does healing fit in with me. To me, I feel that when you're healing you're looking for a deeper peace.

So part of that journey is looking for that deeper peace. Ya. *So that's where you're going?*

Ya, it's kind of like waking up.

Can you talk more about that?

[pause...]

Is there a connection between health and healing?

I feel there should be, what connection I don't know.

How would you describe someone that is healthy?

Someone who is able to identify with, their own, be self aware I guess and be happy with that.

Other things?

I think that we, when you're more self-aware then you're not leaving too much room for stress to come in. When you have stress in your life it seems like that your life is out of whack and uhm, when you're like, self aware you're emotionally sound and physically sound, you seem to know what you want and how you want things to be and your choices seem to be more obvious.

So you're talking about when there's stress that things aren't the way they should be.

To me, the only way that I can control my health is eating healthy and living healthy.

What do you mean by living and eating healthy? Tell me about those things.

Exercise and uhm, watching what you eat, rest, I haven't been getting proper rest lately.

So the fact that you haven't been sleeping lately, would you say that has been affecting your health?

Ya. Uhm, morning seems to come too soon, and I seem groggy to start things off. It's like when you are going to bed and you can't seem to get your mind shut off, so these thoughts are keeping you awake.

So how does that fit in with being healthy or not being healthy?

Physically it drains you, emotionally you're going to have some type of discomfort like being tired all the time. And it's, you're less likely to want to do anything too strenuous because you're already too tired. Like even going for a walk is like a big effort.

Would you describe yourself as being healthy?

I'm not sure. [pause].
What makes you not sure?
[pause]. I find that things in my life aren't balance right now and it's, especially my emotional part of me, so I don't feel, because they're not balanced and I'm affected emotionally that I'm not getting the physical rest that I need, I'm not getting things that I should be getting for myself.
Like, what are some of the shoulds in your life?
Eating properly I guess, I used to have alot of quiet time in my life and now I don't seem to have that anymore and I think it's not because I don't want it in my life it's because I have my aunt and her kids over at my place right now and it's not my lifestyle with so many people. So it's kind of irritating I feel, and when they're gone I miss them.
I have one more question. At the beginning you talked about good medicine and bad medicine. Tell me about those things.
Uhm, see I never believed much in Native medicines for healing, Native medicines for curing, for getting luck or getting wealth, things like that. For me, things in life happen because that's how your walk of life is going. And then that stuff started happening to me, having those visions, then I made it, a different thing for me to think about altogether, it was something that I never considered thinking about before and all of a sudden I was thrown into thinking about it and dealing with it hands on. And uhm, even, someone mentioned that someone could be doing some bad medicine on you so that these things are happening in your life, so negatively that it is causing this fear in you. So thinking about that, I was told that if you didn't believe in that that it wouldn't happen to you. But if I had a believed in it, if I didn't believe in it before and I didn't think about it before or even have any knowledge of wanting to think of what was happening with my life and these visions of these beings then why was it happening to me cuz I didn't believe in it before. That was one of things that the medicine man had told me that I find contradictory. And I had never believed in that before and I wondered why it was happening if he told me that if you didn't believe it wouldn't happen.

Monica

I have lots of questions that I want to ask. Uhm, and part of it is in talking with you there is lots of background, there is lots of stuff about you that I want to hear about. I want to hear about who you are, and how you would define yourself. Cuz I see you as a real powerful woman, I am really in awe of you.
I am surprised [laughter]. I don't say that to be coy, I mean that truly because I truly [pause], you know, I guess I don't see myself as a powerful woman as you say. I see myself as being a strong person and I think that that just comes from my background. You know, I am the oldest in the family of seven children and uh, when I left home at fifteen years old I guess, I had, you know, had a lot of responsibility at home. I left home at fifteen and then got pregnant and had my daughter at sixteen. I have always been in a role where I have had to be very, very strong and together, and you know, in control of things. So I guess I think of powerful as someone like an Elder, that's what I see as powerful. And I think that I certainly have alot to learn. In terms of, you know, who I am today, I will share a little bit about myself from when I was younger. My mother is Cree and she grew up in a convent. So she was there for about eight years, and when she got out she was sort of on her own in the city for a while and met my father who is non-Native. So I identify quite strongly as being a Native person but I also respect very much the heritage and the culture of my dad's side of the family. Uhm, you know, my parents have not had an easy life either you know. So when I was growing up, you know, there was a fair amount of drinking in my family. I can also

remember my mom and dad both fighting alot during the time that they were drinking. You know, it wasn't always my dad that was beating up my mom, it was the other way also. And one particular incident has really been a catalyst for me in my life, you know, so consequently it has really moulded the way I live my life. Like I have never drank alcohol in my life, and uh, you know, I have never done drugs or any of that sort of stuff. So for myself, I made that personal choice, but it seemed that when I met my ex-husband, it was almost like I was attracted to the very things that I so much didn't want to be a part of my own personal choices. And, you know, so consequently I met a man who had lots of difficulty with alcoholism, and later on with drugs and you know, problems with the law and stuff like that. It's interesting that you see me as powerful because I have alot of guilt feelings around my strength also because I feel that that has contributed to some of the dysfunction in my earlier relationship. Because I am a strong person, I took care of things all the time and I think that I see that as my contribution, in not a good way, to our relationship and I see that as being a very, very large contributing factor to, you know, alot of the breakdown with my marriage and uhm, you know, the responsibilities that my ex-husband didn't follow through on and uh, you know, that leading to enabling him to be in his situation. It is a struggle for me every day of my life, it is something that I always have to be aware of and have a handle on.

You used the words "taking care of", what were you meaning by that, taking care of things in the relationship.

Oh man, (sigh), I have always had to, to be the nurturer, you know. I always, you know, it was my responsibility to look after the children and to nurture and to do all the things that were involved with the children, run them here or there. And you know, I also took care of all the financial things in our relationship. But other things too, everyday, mundane kinds of things that I took care of all the time, like yard work and gardening and housework and cooking and shopping.

Things that make the world go round.

Things that make the world go round, and I never had alot of help from my partner. The other option would be to live the way that would have been easier for him which would be on welfare. And I wasn't willing to do that I guess.

And was there a period of time in your life when that was your reality? That you were not working and having to be on assistance?

Oh yes *Can you talk about that a little bit?*

Sure Like I said, when I met my husband I was actually fourteen and I got pregnant with my daughter when I was fifteen. I started getting beat up right from the very beginning and there were times when I left and would have to, you know, sort of struggle to make by as a sixteen year old kid. And, you know, things were just not good. And then my daughter was born and a few months later, my ex-husband went to jail. At that time, if you had a child, you could go on welfare, which I did. And I just, I found such difficulty with the whole thing you know, having to go in there and you know, tell everyone your whole life story, you know, it was humiliating for me, you know, I just found it difficult. And that with the fact that it was really difficult and challenging to live on what you get from welfare. So at that time, when my daughter was only about four months old, I went to work, back to work waitressing as I had done before that, and my parents babysat. Then a second time, when my son was two, I got up enough courage to leave my husband for quite an extended period of time I moved to the Coast, and lived on welfare. And man, it was tough. It was a really hard situation for me.

And did that make a difference, do you think, in terms of who you were, or in terms of how you felt about yourself?

I think it made a difference in how, who I am, for one thing certainly. You know, I've got a

really strong sense of working for what you get and that contributes to who I am in alot of ways. I can remember saying to him, later on in our relationship, like "you are never, ever going to get me down to that level," you know, "you are never going to see me there and you are never going to see me drinking, you are never going to see me drugging, you are never going to see me stealing and you are never, ever going to see me being unfaithful." So, you know, I had some pretty tough rules to follow for myself.

Those were your walls that kept your life together though right?

Very much so, and my children. My children are, they are just so important to me, you know, they really are. And we have lots of struggles, you know, but I am probably sitting here today largely due to them. I think that later on, if it hadn't been for my children, there were times where, you know, I was pretty suicidal and I just wouldn't be here. And you know, I felt alot of shame you know, because on the outside I was this person that people perceived as being strong and in positions of responsibility and you know, my whole life was chaos for many, many years. You know, a very big point in my life, and changing point for me was when I lost my son, you know, that was a real turn around. You know, in terms of uh, just an awareness, because it is almost like, because I was so young when I was with my ex-husband, he's ten years older than me, that is was like he moulded me to be this person that he wanted to see. And it took those different things in my life to kind of go, oh, and for me to have more of an awareness of who I was as a person. I can map major things in that period of time where the changes, the awareness perpetuated other changes throughout that relationship.

So there was a period there, a change.

Oh ya. But I think that who I am today didn't come, you know, in terms of those major changes, didn't come when I was in the relationship at all, they came after the relationship. You know, it really really has been a long haul but I guess alot of who I am now is sort of evolving over time too because I think that I am different all the time almost. Like I am sort of, this is who I am, but there's things that uh, that are evolving about my character in terms of speaking up for myself and, just [*accepting alot of things about myself*]. But you know, again, accepting those things in myself, because I think that you need to accept them in yourself in order for other people to accept that. Sometime I feel like a little kid, you know, like I am learning all of this stuff now that most people learn back there when they are teenagers, you know.

And part of that, or a large part of that is that you had children when you were so you and so you went from being a child to a mother, right?

Yup, ya. So, those are all things that I have experienced. And health wise, all of that stuff has really had an effect on me too. Cuz I used to be pretty healthy person, but now my body is saying to me, you know, all of those years of tapping that stuff down and living in a stressful situation, I am responding to it. It's catching up to me now.

Can you talk a little bit about, you said that you were healthy then, do you see yourself as being the opposite of healthy now? I don't know what word you would put there.

I see myself the opposite in terms of physical health, in terms of, uh, I don't know if it was even in physical health because I certainly had the flu then, I certainly, uhm, I had a [some surgery for certain things], you know, I had all those things happening but it wasn't acceptable to be sick. It wasn't acceptable to just lie down on the couch because you weren't feeling well. So I guess that's what I see as different, because now I do. If I am sick, I stay home and lay down. So, you know, I guess I say that I was healthy then and I wasn't now and it wasn't really that way, but in terms of it being acceptable, it's like the difference between night and day. And I think also, for me to, you know, I'm on a healing path, and for me, what I try and

do alot now, instead of internalizing it or feeling sorry for myself, I take that stuff and I literally do, I thank the Creator for that because that's how I learn, and that's how I grow, like from those experiences. And I feel humble, and I have to thank the Creator for that also because I'm still here. So I guess that I also feel that those things happen for a purpose. That's all part of who I am and how I choose to live my life now, and how I choose to move forward on my healing path.

I have many questions that I want to ask. One of the things that I was thinking about is the whole concept of Native spirituality and smudging and, you using the words "the healing path". And I still have alot of confusion about Native practices and Native spirituality. Can you shed some light on that for me?

I have to admit that I have alot of confusion too because I didn't grow up in a traditional home and these feelings around being Native and identifying as being Native, have happened to me pretty recently. I haven't all my life felt good about being a Native person, it hasn't happened that way. But I guess that it is something, I really identified with over the last five years, which incidently, is about the length of time that I have been separated from my ex-husband. And you know, it was my friends that were involved with me that were Native people that helped me through that [*time after leaving her husband*]. I have a friend that is a spiritual advisor and a pipe carrier. The way she talked to me is that when you're involved in the cultural aspect that she was talking about, and she's also pretty into the spiritual aspect, is that it's involvement in a way where you don't judge people. Where you respect people for who they are and you allow them their dignity, and for me that fit. Because that's what I wanted, I wanted people to accept me and I wanted people to respect me and allow me my dignity and to be who I am. And that was something I guess, finally when I talked to her I heard that but it was something that I wanted for here [points to heart] all of my life. At first I just started smudging at home and doing that kind of stuff, I felt that it was right, I do it in the program, and then I started working with our spiritual advisor. And, you know, it fits very much for me, just because it's something that I have always wanted in my own life.

What does health mean to you?

Well health means to me, a couple of different things. It means well-being, I guess, you know. Speaks to me a large part in being healthy, you know, my personal well-being. Because during the time that I was in that abusive relationship I didn't have any physical health issues, you know, like I was fairly healthy. But in terms of my well-being I was not healthy at all. But now, I almost feel like it's completely reversed, the situation. That I'm not in that relationship anymore and my well-being, I feel pretty, pretty stable emotionally, mentally and physically, and the most important, spiritually. That has really helped me. But my physical health has really been impacted by the relationship, and I know that it had a large part to do with some of the health issues that I have now. You know, in terms of being overweight, was a big thing for me. You know, I never, ever drank or had done drugs but my comfort was food, you know. And when I was unhappy or angry or whatever, I would eat. The food was a symptoms of other problems that I was having. Before I wasn't allowed to be sick because who would look after my kids, and who would work and who would do all that stuff. There wasn't anyone to do all that. So I just kept on going and I dealt with those issues and feelings by eating, and you know, I struggle with that now. I still find that I really struggle with that. Because now I think that it's become an addiction. That's what I feel that the biggest, or the largest, impact on what I feel is my health is my well-being and not my physical health but my emotional and mental well-being. For me that speaks to health. Because I really feel that I have been impacted by stress, and like my self-esteem, and my value and my self-worth, that has impacted some of the symptoms that I have in my physical health today. And I think that

I'm where I am today, in order to feel emotionally and mentally well, the spiritual element of my life has really had a large impact on that. A very, very large impact.
When I asked me about the meaning of health, you started by saying that it sort of meant two things for you, one was well-being, did you kind of cover what you wanted to say in terms of mental and emotional parts?
Ya, I think so. To me, I guess that's, I don't think that it's all one thing. You know, I think that there's the physical, but for me, I think that the health is well-being. And I think that, I don't know, I really do that if you feel good about yourself and you feel safe, you feel loved, that how you feel physically relates to that. And I think that somewhere along the way that they mesh too. You know, like, I have seen, it has been my experience that there's emotional well-being and there's this, and for me they have kind of come together and they are meshing. Because you know, I feel safe and I feel loved, and you know, I have health issues and I'm dealing with them because that was the other thing, that I was scared to be sick. So now my emotional well-being and my health, my physical well-being are like this [joins and interlocks fingers] rather than being separate.
And what you are dealing with area chronic medical issues, they aren't going away.
No, right. But I thought they would [laughter]. I thought if I just forget about this, it will be better [laughter].
But it's finding out where that fits almost, right? Where it fits with your life?
Ya. And feeling comfortable with that. Because I have never felt comfortable with being sick, to me, being sick is helpless and useless and I couldn't allow myself to be that. So I guess I just pushed stuff back, and so, I wasn't, it worked, I think, to a certain degree although it manifested itself, like I said, in the eating behavior. So now I am addressing it, and yes, this is something that I can do something about, and yes, I am going to be better. You know, because the couple of things that I have been struggling with have been chronic things that are not going to just go away by itself, and I know that now so it's working better. So now it's coming together for me now like this [gestures with hand together through interlocking fingers] , more like this than being separated and kind of going this way [moves hands one over the other]. You know, my physical and emotional, mental and spiritual, it's all as important as each other. It's more of a balance for me I guess. Because before it did, for a while there I was so sick, physically I had so many things happening that it [physical self] just kind of took over our whole life. It was at the forefront, and you know, there have been different times in my life where that has happened, were sometimes the emotional problems will be at the forefront. But I think that I'm getting better at dealing with those and the periods of time where I change from one to the other aren't as great. I know that for my health now that I need, it's my physical, my mental, my spiritual and emotional, it's all balanced. And so that philosophy that I talk about with healing is very true for me. And I don't know if it is for everybody. But I know that it is for me.
So you use the word healing, and you have used the word health. Is there a relationship?
I think so.
Tell me about that.
I think that there's a relationship, I don't know, sometimes I think that it's the same thing. And I can't describe what is health and what is healing because it means different things to me at different times. You know, like I feel, that I am on a healing path. To me, I am moving on a road that talks about the well-being of me, whatever that may be. To me, it's choices and decisions that I make about me, that's what I look at as my healing path. So, but I see that health is part of that because I have to make decisions about my health and my emotional well-being to move ahead every day. So I see it, sometimes I see them as really, really being

part of each other and sometimes I don't. So healing and health, I don't know if there is a difference. Sometimes there is, sometimes there isn't.

What you are telling me is that those things all depend on the situation, on the context. And it depends on the individual.

Ya, for me it does. And I can only speak for myself and what my perceptions are. You know, and I guess that's one of the great things is that I love to hear other people talk about things like that and every once in a while you hear these people talking and think "ya, that talks about me too." You know, and sometimes I am able to speak to that and sometimes I'm not, just depending on where I'm at. So, you know, health and healing are the same thing because health, you know, I guess the other thing is that I see health as the physical and the mental and the emotional, and I think that healing is the same thing. You know, in order for us to move down that path we need to be healthy both emotionally, mentally, you know that emotional and mental I see as being part of it, and physically, and I think that uh, but even if I am not physically well, like I mean walking about and seeing and all that, I know that I would still be moving on a healing path. And I think in some respects, I would still be healthy. If I still felt safe and I still felt accepted and I still felt loved, I would still feel healthy. Because to me, that's the most important thing in my life, is to feel safe and accepted. Those are things that are pretty important to me right now.

Someone else was talking to me about good medicine and bad medicine. What can you tell me about that. Do you have stories you can tell me about it?

Ya, there is. I think, to me, good medicine speaks to, you know, I really think that the Creator is there for you, even if you make mistakes, if you're doing it with the best of intentions, I think that the Creator is there with you and understands that. And I think that there are some people that use some of their skills and some of their knowledge in a way that is going to benefit them and maybe not benefit other people. I see that as being bad medicine. I think that also, there are people out there that are looked upon as leaders, and I see that some of the things that they do with people can be viewed as bad medicine because they are looking at their own personal gain. I see when we make judgements of people, that's bad medicine. Again, I think that it talks all about accepting people for who they are. I think it's bad intentions, which in turn speaks to me of bad medicine.

Appendix F
Examples of Bad Medicine

Janice:
Another story [about medicine] was with one of my uncles who used to be really athletic and sporty, and I guess, you know, could have done alot for himself. My mom always believed that someone had done some type of medicine to him, some type of bad medicine 'cuz he was in perfect health and doing really good and then all of sudden he went to a tournament. I can't remember if it was ball or hockey, but from that tournament on he was never able, he was never really himself again, he was never really able to play to his full extent. He always had some type of problem, always.
Are you talking about physical problems?
Ya, physical. Which is kind of strange, like all of a sudden. And it sound unbelievable but when you see him and you know, it just, it make me wonder. And I, every now and then I hear, more so when I was younger than now, I would hear at sporting events, Native ball tournaments or Native hockey tournaments and people would mention, "hey, they have medicine." So I don't know if they were saying it, you know, it could be a rumor or whatever.

There's one more [story] and it's quite recent. My mom's sister is uhm, my mom believes that the fellow that she is with has actually done some type of medicine which makes her stay with him. Because they have been through so much and he's into drugs and drinking and stuff, and he puts her through so much but she won't leave him. She, no matter what he does to her, no matter what, she won't leave him. And he, I don't know, my mom just believes that. And you know, I said that if you believe that, why don't you take her to see someone that can do something about it, someone with good medicine. And ya, but who, we don't know who.

Jody:
Have you been in situations where you have know about bad medicine? [nods]. Can you tell me about that?
I don't know what happened, but I was told it was some kind of bad medicine that was used on me when I was about nineteen. Where it seemed that I left my body. Like I was in bed, we all went to bed early, and in the middle of the night I felt that I really had to go to the bathroom, or something like that. I woke up, I couldn't move. Nothing in my body would move. My mom and dad were just in the next room, so I called out to my mom. She never came in for a while because she couldn't figure it out, but then she did come and I was just like, there was no life in me. And all of these things that I thought I was saying wasn't coming out - there was nothing. I was like this for, what seemed like a long time. Mom had to go and get somebody from the community that does this Native healing type of thing. She came over and did prayer on me and all this stuff. Some holy water, I can't really remember. And then I was able to come out of it. It was like I wasn't in my body. I could see what they were doing to me on the floor.

Karen:
I had just returned from attending a funeral and started uhm, hallucinating, having weird things happening to me. It was really scary. I never, never, ever thought about good medicine and bad medicine, evil people and good people. I always thought like one in the same. People don't try and intentionally hurt you. So when I started getting these things happening to me, it was really, really scary and I had a hard time sleeping. I would actually see little tiny beings in my room, in which they had really long evil hands going through my hair and I was frozen. And all I could feel was the side of my eyes blinking, it was like I could feel them moving in the sockets. It was, I don't know, you're really aware of everything around you, including your eyes blinking. And uhm, someone mentioned that someone could be doing some bad medicine on you so that these things are happening in your life, so negatively that it is causing this fear in you. And in my bathroom I found one of those puff balls, I'm not sure what they're called. You find them in the summer time and they're really dry and when you step on them a bunch of puff, powder comes out, like smoke or something from these things. I found one of those in my bathroom, on the floor behind the toilet, and for that place in the house it was really dry, and I thought it was a cloth or something, and as soon as I touched it my finger poked through it, that's how dry it was. This powder, a whole bunch of smoke came out of it. All over my hand as well. I didn't think much of that, but these visions started seeming more, like happening at any given time. Basically when I was alone. My body was freezing and I would have another vision and someone would be laughing at me, and I would be hearing their thoughts, like they weren't talking but their thoughts would be like they were talking out loud to me because I could see that their lips weren't moving. They weren't speaking, but I was hearing their thoughts.
These little people?
Ya. They varied. I never saw the same one twice. And uhm, the one that I'm talking about now, it was just part of them, the head and no body, of a person, and what person I don't know. The voice was really loud, and stuff like that would happen to me. I would have my own thoughts and I would feel that he would hear my thoughts, like talking across from each other. And the one time I was saying this can't be happening to me, I'm stronger than you, and the voices saying back to me, "ya, right" and it was mocking. This stuff started happening more so after I found that thing.

Appendix G
Additional Life Vignette

Peggy

I find that if I don't work I get bored. The smoke [at work] is just something that I have to deal with. I need that job. It was hard for me to find one.

Peggy is a young status Carrier woman who lives at home with brothers, sisters and parents. She attends school full-time and works as much as she can to buy clothes and do the things that she wants to do. She grew up in a home where money was tight; where her mother had to learn to stretch things, especially in relation to getting fresh fruits and vegetables. For Peggy, work and money are tied to the value of what material possessions afford her happiness and comfort. Peggy is talkative and friendly, an individual who seems easy to approach. She seems to have a genuine enthusiasm for what she is doing and takes a special interest in people. Peggy is one the youngest in her class at the Learning Centre, and for what she lacks in life experience, she makes up for in questioning and inquiring attitude. Peggy talks about her job as influencing her health:

> Because all the smoke there, that's unhealthy, but also I get exercise there, that's healthy. And I get a paycheque that helps my self-esteem, that I'm doing something. I also have money to buy clothes, and that makes me look better...I like going to work, it keeps me busy and gets me out of the house.

She talks about the past and the influence of learning in relation to how that has changed the direction of her life, and in some ways perhaps, her view of others.

> When I was thirteen I was really into drugs. I needed something bad and my friend, who I thought was my friend, gave me some pills, too many pills. I ended up in the hospital getting my stomach pumped. After that, I started volunteering and school picked up, I was doing really well in school. And I was helping through my volunteer work, that was good. Since then I haven't taken any pills.

For Peggy, health means eating right and exercising, although she qualifies "eating right" by adding that it's "eating what you want to." When questioned further, Peggy expands this original meaning to include feeling good about yourself, not taking medications, and feeling happy with the decisions that you make. Talking about medications, Peggy explains:

> I don't think it's healthy to take drugs. I don't take any type of prescription. I have seen people that take one Tylenol to fix their headache and pretty soon they need four or five...I think that I learned some of that stuff from my mom, she doesn't take any pills either, no prescription drugs. She just doesn't think that that's the right thing.

Health and healing are seen to be the same thing according to Peggy's perspective with physical and emotional dimensions. In speaking of this, Peggy refers to a sense of balance, a sense of well-being. She views physical health essential for emotional health. Emotional health is being able to talk about feelings, liking yourself, feeling good about yourself, and have self-esteem.

> Like, you need to have the energy and the strength to feel good physically so that you can deal with your emotions. I really talk about what I'm feeling, I talk about my emotions. I have never been one to hide that. But some people do and I think that's unhealthy.

In addition, individual and subjective meanings of health are explored in the response to the researcher's question about "what does a healthy person look like?" Peggy explains "that I can't really speak for other people because I'm not with them all the time. I don't know what they do."

Two other terms that Peggy uses in her explanations and answers to questions are the words "balance" and "wellbeing." For Peggy, balance fits with a sense of well-being, and could be visualized like an ecosystem: if one thing is out of balance, then it's all out of balance. Well-being is described as "feeling good about yourself, about who you are, and what you are doing."

Reflections of Peggy

On first impression, Peggy is an energetic and enthusiastic person. Her energy seems to extent beyond her physical self, and is almost infectious. She readily responds to questions that are somewhat pragmatic, other questions that are perhaps more philosophical and global produce more stilted responses. Peggy talks frankly about her early teen years, and I find this frankness somewhat unsettling. Perhaps this is the "social distancing" that Andersen (1993) talks about, and I wonder if she does this to see what type of reaction that she will get from me. Is this a way of testing me to see how genuine I am? Or is she simply at peace with the way that she was, and has incorporated those historical aspects into her present understanding of her self?

Peggy spends time emphasizing that she talks about her feelings, that this is something that is critical for health, and for healing. I think that I reward this insight in my interviewing through trying to get her to expand this to other people, how this "talking" is good for other people. She closes this track down, and in doing so, reinforces for me that interpretation and conclusions are personal; that this cannot be indiscriminantly extended to others. I wonder about the issue of respect, is the fact that one does not speak for others a sign of respect? I begin to think that the aspects of talk from Peggy are somewhat superficial, and then I reframe this to relating it to her embodiment; her age, her life experience, her relationships. The element of time again creeps into my consciousness, what is it about time that influences one's conceptions of health? From my perspective, I think that time is related to experience, and it is through the experiencing of situations and events that insight is gained, and further experience is formed.

With Peggy, I feel that our relationship is that of two strangers. We have had minimal interaction around the Centre, although she did attend the Healing Event in November and I did interview her regarding that experience. My original intent in asking her to participate in the research was because she is of Carrier decent, and my plan initially was to limit my informants to those of Carrier ancestry. However, that proved to be a challenge in terms of the people that I was meeting, as there are many Nations represented in the people that attend the Learning Centre. I think that for Peggy her life is somewhat "uncluttered" by both the baggage that people carry, and the relationships that add much complexity to life.

Through additional reflection, I begin to wonder if the reason I see our relationship as that of two strangers is that to some extent we both have an outsider status. For me, my outsider status is apparent - I have identified myself as a researcher, and as a nurse. I am visibly different from the majority of people that work at and attend the Learning Centre, in that I am White. For Peggy, her outsider status may be somewhat transient; being included as an insider by some, and as an outsider by some. She is the youngest in her class, not afraid to ask questions, and readily gets involved in class discussions. Peggy lacks the past socialization of years of oppressive schooling that many of the older students have endured.