ANISHINABE GRANDPARENTS: PERCEPTIONS OF LIVING WITH THE EFFECTS OF TYPE 2 DIABETES

BY

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ABSTRACT

This qualitative research study explores Anishinabe grandparent's perceptions of living with type 2 diabetes and its effects on grandparenting. Using ethnographic and oral history methodologies, guided interviews were conducted with five Anishinabe grandmothers and grandfathers living in an urban area of Manitoba. The objectives of the research were to gain insight into how they perceive their grandparenting and to identify the ways in which their roles and responsibilities in child rearing have changed.

The results presented three theme classifications: grandparenting, health and education. The major findings demonstrate that it was the participant's grandparents that influenced them in their roles when they became grandparents but find that they have to modify those ways now because of the diabetes. The participants did experience many health problems related to their diabetes and found that it diminished their role as a grandparent. The majority of participants believe that education is key to the prevention or management of diabetes. There was a strong consensus that learning to live with the disease and not let it control you is vital for coping with it (continuing with life).

In conclusion, participants could identify traditional roles that their grandparents performed but found that they are not able to enact these same roles because of colonial practices, changes in the family system and environment, employment, and residency patterns. There exist many perceptions from participants that type 2 diabetes does affect the grandparent role and quality of interaction with grandchildren.

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CHAPTER 1: INTRODUCTION

First Nations families have been organized in an extended family kinship system since time immemorial. Grandparents, as elders and teachers, held a special place in the family. They were respected for their wisdom, life experience, and their tribal knowledge about social relationships and family life. The grandparents, as elders and educators, contributed to families by transmitting their knowledge about life to family members through an oral tradition. They played instrumental roles in guiding the parents of children and teaching the children about their future roles and responsibilities as males and females (Blanchard, 1977; Hart, 1995).

In Canada, the Anishinabe people (Ojibway) have survived many governmental policies that served to systematically erode their traditional family systems and cultural ways of life. The constant governmental assault to erode the traditional Anishinabe lifestyle and family patterns resulted in the dispossession of the First Nations people's lands and resources (Grant, 1996). It also served to disrupt family relationships, the transmission of traditional knowledge, language, cultural teachings (such as laws, religion, education, health, social relationships, morals, values, and norms) and customary family and community practices in child rearing. The disempowerment of First Nations family kinship organization has caused much confusion about the enactment of family roles and responsibilities. In the past Anishinabe grandparents knew what their roles were and what was expected of them in regard to child rearing; however, now they often feel unsure of what is expected of them by their families due to cultural change (Blanchard, 1977; Grant, 1996; Ing, 1991).

By present-day Canadian socio-economic standards, most First Nation peoples across Canada are considered to be living below the standards established by Canadian society. The severe socio-economic disparities that exist between the dominant culture and First Nations people are repeatedly evident in research conducted on them (Bobet, 1997). First Nations people's health status is particularly alarming when one examines the morbidity rates for chronic diseases, such as diabetes (Young, Reading, Elias, & O'Neil, 2000). The increasing prevalence of diabetes is a significant factor that is currently jeopardizing the stability of the Anishinabe grandparent population and is having a devastating impact on family and community relationships (Cyr, 1998).

In the review of literature of this qualitative research I will discuss a number of historical events such as the erosion of the traditional subsistence patterns of the Anishinabe people and some of the colonial models that have served to disempower and assimilate First Nations people. This research focused on getting a current perspective from Anishinabe grandparents on their changing roles and responsibilities in relation to child rearing in light of their social circumstances and health conditions.

For the purpose of this study five Anishinabe grandmothers and five Anishinabe grandfathers diagnosed with type 2 diabetes were interviewed to gain insight into how they perceive their roles in child rearing and to get an understanding of the difficulties involved in maintaining and sustaining a significant relationship with grandchildren. The interviews were guided by a series of questions posed to grandparents of what they do with their grandchildren and what the grandparents remember their grandparents teaching them. The methodology was framed utilizing two research approaches: ethnography and oral history. The goal of this research was to identify the ways in which Anishinabe

grandparents' roles and responsibilities towards child rearing have changed. The research demonstrated that Anishinabe grandparents are continuing to play an important role in child rearing; however, their approach was different than what they are able to recall from their grandparents' roles. Furthermore, the research demonstrated that four of the ten Anishinabe grandparents with diabetes are under a great deal of emotional stress and role strain in fulfilling their traditional cultural obligations as grandparents. Four out of ten Anishinabe grandparents interviewed reported this to be their experience.

Purpose

The purpose of this study was to gain insight into how Anishinabe grandparents who have been diagnosed with type 2 diabetes view their roles and responsibilities in child rearing and their interaction with their grandchildren. This research focused on the social impact that diabetes is having on the grandparent – grandchild relationship.

Objectives

1. The first objective was to identify traditional roles of Anishinabe grandparents in the extended family system as recalled by grandparent participants.
2. The second objective was to get the perspectives of Anishinabe grandparents on their roles and responsibilities in child rearing and to determine if they think they are performing the grandparent role differently from the ways in which they were grandparented.
3. The third objective was to examine perceptions of type 2 diabetes affecting Anishinabe grandparents and to analyze its impact on the grandparents' ability to perform their traditional child rearing roles.

Definitions

The term *Aboriginal* is used in this study in reference to all people who identify themselves as Status, Non-Status, Metis, or Inuit.

The term *traditional* is used in conjunction with the teachings and cultural practices that have been known to the Aboriginal people and passed through an oral medium.

The term *Anishinabe* refers to the long time indigenous inhabitants of the southern region of Manitoba, also referred to as Ojibway in English or Saulteaux in French.

First Nations people are those with treaties with the Canadian government. Tribal elders and representatives of the British Crown signed treaties from 1871 to 1921.

CHAPTER 2: LITERATURE REVIEW

Pre-Colonization

In the era before European contact, often called the pre-contact era, North American Aboriginal peoples were believed to have been in good health largely due to their nomadic lifestyles and food sources. Young (1988) states that Aboriginal health, cultural identity and spiritual well being was linked to the land and what it provided for the people. Although starvation was always a threat to Aboriginal hunting societies living in harsh environments, they were able to adapt effectively and sustain themselves by what they obtained from the land. Aboriginal people believed that they were a part of nature and a balanced ecological system (Cajete, 1999).

In Manitoba, the Anishinabe were socially and economically organized into extended family units. According to Peers (1987) and Ray (1998) the extended family units were comprised of several closely related families such as a hunter and his wife and one or more of their married children with their offspring or several adult brothers and their families. Members of the extended family unit also belonged to at least two clans. Peers states that every Ojibwa "belonged to a patrilineal, exogamic descent group or clan which was named after an animal" (1987, p.32). The extended family and clan systems provided the philosophy of interdependency, the boundaries of relationship, and responsibility and expectations of its members. The development of these complex kinship patterns served as a social security system in times of need (Blanchard, 1977).

The size of the family units varied from season to season, depending on the seasonal migration and availability of animals that were their main food source. Ray

(1998) states that the winter family unit was the most important. This family unit was smaller and its main purpose was economic. Families lived in the forest and often shifted locations to hunt and trap. In the springtime, families would collect maple sugar and live off caches of meat and wild rice. In the summer, Anishinabe families came together and participated in large social gatherings, usually at fishing sites. During the summer gathering the Anishinabe hunted bison, planned for the winter, traded goods, and took part in social (games, marriages) and religious (Medewiwin teachings) functions (Peers, 1987).

The seasonal movement of the Anishinabe in pursuit of food combined with their hunting and gathering practices ensured a range of mobility and a high level of physical activity (such as walking, running, and canoeing) and endurance. Hunting was the main activity of the men and was highly organized around the survival of the group. Young (1988) states that "Both self-reliance and mutual cooperation were essential to survival. Values such as sharing, generosity, and hospitality were well suited to aboriginal hunting life, and they have by and large endured into the present" (p.14).

All of the family members had different roles and were involved at some level in the quest for food and in the preparation of it. The Anishinabe diet consisted of meat sources such as bison, deer, moose, elk, beaver, and rabbit. The Anishinabe also ate a variety of wild fowl, plants, corn, wild rice and berries. The food sources were low in fat, low in sugar, high in protein and highly nutritious. The food was prepared by the women who used cooking techniques such as boiling, streaming, smoking and

sometimes preserving the food naturally in animal fat for later use (Chaddock, 1998; Peers, 1987).

Anishinabe people had a division of labor but considered themselves as equals even though work was divided by gender. For example, Anishinabe men hunted for food, fur, and other staples. They were the principal negotiators of economic trade, hunting territories, social and political alliances. The men also belonged to a warrior society and provided military defense for their group and hunting territory (Peers, 1987; Ray, 1998).

The Anishinabe women on the other hand skinned animals, tanned hides and prepared the meat. Anishinabe women were also in charge of the children and the home. However, since child rearing was viewed as a shared responsibility, all of the adults and older children helped in the education and training of younger children (Blanchard, 1977).

The child was received as a gift from the Creator to be protected, loved, nurtured, respected and guided. Children were encouraged to play, observe and model the Anishinabe way of life through the oral tradition and community expectation. Children were taught gender roles and what was expected of them by imitating same sex adults. Children learned what their future roles, expectations, and responsibilities would be as they matured from teachings and through play with grandparents. When the child was believed to be developmentally ready to conduct certain tasks and functions he or she was encouraged to do so with the guidance of grandparents. The children also learned their culture and history from stories told by

grandparents. As well, grandparents gave the child a religious and moral foundation by teaching them about earthly and spiritual life (Blanchard, 1977; Whitecap, 1988).

Anishinabe grandparents provided traditional knowledge and guidance to all members in the family and community. They were esteemed for their life experience, wisdom and understanding of traditional ways of life. They were valued in their role as advisor and teacher who transmitted the culture and language to successive generations. Grandparents spent a lot of time with children. In addition to teaching the children about the Anishinabe ways of life, grandparents taught the children skills that they would need in order to function in the society.

Colonization

Adams (1995) and Hudson and McKenzie (1981) discuss how Eurocentricism formed the historical basis of Indian/White relations and the logic of colonialism. Adams (1995) states that colonialism is a process of one group of people dominating the economic, political, social, and cultural spheres of another. Hudson and McKenzie (1981) provide a further distinction between structural and cultural colonialism. They state, "Structural colonialism involves the explicit control of power and decision-making by the dominant group for the purposes of extracting benefits, and cultural colonialism involve efforts at normative control" (1981, p.65). There are numerous examples of how both types of colonialism were interwoven in the fur trade period to justify the takeover of land, natural resources and people.

Young indicates that "By the early and mid-eighteenth century, various accounts of the Indian's health began to appear in the journals of traders and explorers in the hinterland of Hudson's Bay. Andrew Graham of the Hudson's Bay Company wrote

in 1767 that the Indians in general exceed the middling stature of Europeans; are straight well made people, large boned, but not corpulent" (1988, p.34). The Aboriginal peoples' good health status was also linked to their dental health. "Peter Grant reported that 'their teeth, of a beautiful ivory white, [were] regular well set and seldom [failed] them, even with the most advanced period of life" (Young, 1988, p.34). However, after rapid European settlement, the general health of Aboriginal people across the nation quickly declined. The deterioration of Aboriginal health has been linked to the introduction of European diseases, technologies, whiskey, and food staples, as well as to the exploitation of the land and resources and the ensuing famine and starvation that followed the fur trade period (Young, 1988).

As European settlement progressed, Canadian Aboriginal people, including the Anishinabe, became increasingly acculturated into the emerging Euro-Canadian society. The fur trade period was instrumental in influencing many socio-economic and cultural changes in the Anishinabe peoples' way of life. Fur trade commerce brought about extensive social disruptions in residency patterns and kinship relations. This is evident in the history of intermarriage that occurred between European men and Aboriginal women in order to cement political and economic trade partnerships (Van Kirk, 1993). The fur trade alliances were destructive to Aboriginal people. They spread diseases and caused epidemics, violence, wars and famines. The economics of the fur trade was central to the cultural disintegration that occurred in Anishinabe society (Young, 1988). Although the Anishinabe were introduced to new technology and trade goods, whiskey, processed foods, and food staples such as

sugar, flour, and salt, these new products would prove to be very harmful to the future health of the Anishinabe (Friesen, 1984).

By the mid-nineteenth century the animal populations were depleted to such low levels that the Anishinabe could no longer sustain themselves from the land. During this period, the Anishinabe families and communities underwent significant socio-economic, cultural and demographic changes. First with game depletion, the Anishinabe no longer had an economic role to play. The traditional migratory lifestyle was no longer viable and Anishinabe families maintained unstable trade relations with the trading posts based on extensive credit for consumer goods (Young, 1988). Most Anishinabe families were starving and relied heavily on charity from the trading companies (Friesen, 1984).

A second major change came from a series of government sanctioned "Indian" treaties, laws and regulations and the development of reserve lands. The Canadian government's goals of building a national railroad and an agricultural economy were underway, and Aboriginal people were seen as an obstacle to nation building. These "Indian policies" along with the Indian Act (1876) served to justify land expropriation, social control, and cultural genocide and to restrict and control the lives of the Anishinabe people. Friesen discusses how the Canadian government used "food rations as a means of coercing reluctant Indians into the treaties and later, as a tool for controlling Indian diplomatic activity" (1984, p.150). As a result, the Anishinabe along with other Aboriginal people became marginalized and reduced to wardship on reserve lands with no attention paid to their health and overall development (Friesen, 1984).

The Canadian government employed Indian agents and embraced the help of church officials and missionaries to police, civilize, Christianize, and educate the Aboriginal people (Friesen, 1984; Van Kirk, 1993). The government then changed the Indian Act in 1894 to require formal education for Aboriginal children (Ing, 1991). Indian agents served as social control agents for the government controlling the movement and actions of the Anishinabe. Indian agents also received delegated authority to apprehend Aboriginal children from their family and community and place them in residential schools where the focus of education was forced assimilation into the dominant culture. The Canadian government would sanction life threatening and punitive action such as withholding food rations or incarcerating parents who did not comply with the removal of their children by the Indian agent (Grant, 1996; Ing, 1991; Miller, 1997).

The missionaries had additional roles to those of the Indian agent. The missionaries acted as the moral authority over Aboriginal people and as surrogate parents of Aboriginal children in residential schools. The residential schools were viewed as a more effective means of assimilation than reserve living (Miller, 1996). Ing (1991) states that in order to transform the Aboriginal children into White people, all contact with their culture and family, especially the old people, was eliminated. The government and church officials recognized the influence of the grandparents and feared that the children would resort to their old familiar ways if they came into contact with them (Ing, 1991). Ing further adds that the curriculum developed for the Aboriginal children was "a program of cultural replacement and assimilation" (1991, p.74).

The Aboriginal children in residential schools were confused as how to act and felt emotionally, mentally, physically, and spiritually traumatized by their experiences (Grant, 1996). Many children displayed substantial delays in their emotional and social maturation as a result of their deprivation, isolation, and segregation in residential schools (Lederman, 1999). Without family interaction and bonding the children did not learn love, trust, security, identity, and a sense of belonging. They were not allowed to express their loneliness, sadness, hurt or confusion about what was happening to them. Grant states that "Students in residential schools were not encouraged to express feelings; in fact, it was usually forbidden under the guise of defying authority. Discussion was treated in the same way. Children soon learned not to argue, explain, or even question" (1996, p.198).

The impact of residential schools on the parents, grandparents and other family and community members was devastating and extensive. Family relationships were destroyed and traditional knowledge and cultural practices such as child rearing practices were suppressed further eroding the children's identity, language, and understanding of their connection to their traditional ways (Grant, 1996; Ing, 1991). Parents' and grandparents' roles were taken from them and the grandparent role, as cultural teacher became less important. Ship says that

> Aboriginal elders are more likely to live with elevated levels of stress in their lives as a result of poverty, unhealthy living conditions, cultural disruption and the related social problems in the family and in the community. Elevated levels of stress are also related to loss of language, loss of culture, loss

> of positive self-identity and a range of personal, family and social problems resulting from residential schooling syndrome, racism, ageism, sexism, discrimination and stigmatized minority status (Ship, 1998, p.7).

As the children raised in residential schools began to have children of their own, they encountered many difficulties in parenting which many would later attribute to their residential school experience (Grant, 1996). With nowhere to turn for help many residential school survivors relinquished or had children apprehended from them and placed into child welfare custody. The legacy of colonialism over Aboriginal families continued under the extension of the child welfare system (Hudson & McKenzie, 1981; Ing, 1991).

In the 1940s two health and nutritional surveys were conducted among the Cree and Anishinabe of northern Manitoba and Ontario. Young states that "The Indians surveyed showed deficient intake of calories and most types of nutrients, far below the recommended allowances of the time" (1988, p.42). "Low body weight, not obesity, was then considered to be a problem at most age groups" (Young, 1988, p.63). The results of the surveys were significant in that they drew public attention to the health conditions of the Aboriginal peoples living on reserves. Young says that the surveys "gave impetus to the massive government intervention in the post-war years" (1988, p.42).

Sociocultural and environmental changes to the Anishinabe lifestyle such as a sedentary lifestyle, unemployment, a change in diet, poverty, stress, cultural barriers, and a colonial relationship marked by increased dependency on external institutions

are just a few of the conditions that have been associated with the emergence of chronic diabetes in Aboriginal populations (Skinner & Silverman-Peach, 1989; Young, 1988). In the last 50 years additional factors such as hunting and fishing restrictions imposed by the governments and environmental pollution and contaminants in wild game and fish have contributed to the growing difficulties of Anishinabe people continuing their traditional subsistence practices (Kewayosh, 1993). Abonyi states that "diabetes is understood on the one hand as a physical sickness with links to genetics, biology and environment, and on the other hand as a symptom of historical contingencies and contemporary inequalities" (2001, p.4).

Type 2 Diabetes Mellitus

Diabetes mellitus is a condition where the cells in the pancreas "do not produce the right amount of insulin or the body is unable to use the insulin correctly that is produced, or both" (Aboriginal Diabetes Association, 2002, p. 15). The body needs insulin to change the sugar from food into an energy source called glucose. "Glucose needs insulin, a hormone produced by the pancreas, in order to get into the cells" (Maclean & Oram, 1988, p.11). An inadequate amount of insulin in the body can result in sugar staying in the blood and producing a high blood sugar level. Over time, this can result in serious damage to vital organs such as the eyes, heart, kidneys, nerves, blood vessels and circulatory system.

Type 2 diabetes or non-insulin-dependent diabetes occurs "when the pancreas is either not releasing enough insulin or the insulin is not working as it should, not performing its proper job" (Aboriginal Diabetes Association, 2002, p.15). Skinner and Silverman-Peach state that type 2 diabetes is "no longer considered a single

disease entity" but a formation of related pathologies resulting in exceedingly high blood glucose levels (1989, p.4). The symptoms of type 2 diabetes are subtle and often go undetected for long periods of time until severe damage has already occurred (Chaddock, 1998). This is one reason why type 2 diabetes is viewed as a silent epidemic. Researchers speculate that they have underestimated the actual numbers of yet undiagnosed diabetes cases (Ship, 1998).

Some researchers have referred to type 2 diabetes as a "lifestyle disease" because it is preventable. The present allopathic medical model places the burden of responsibility of disease management of diabetes on the individual, which is in contrast to the Aboriginal cultural perspective (Chaddock, 1998; Gregory, et al., 1999). Others have called it a chronic disease of Westernization, modernization, or acculturation "because they attend to lifestyles of western industrial nations: reduced physical exercise; diets overloaded with fat and sugar; high levels of stress; and increased exposure to a wide range of pollutants in the air, water, and food supply" (Ship, 1998, p.5).

Prevalence of Diabetes Among Aboriginal People

The prevalence of diabetes among the Aboriginal population did not come to the attention of health authorities until the 1970s, and it has steadily increased to epidemic proportions (Young, et al., 2000). Researchers state that of all the diabetes cases in the Aboriginal population, 90% of them are type 2 diabetes (Chaddock, 1998). Ship (1998) states that by 1997, diabetes rates were three to six times higher in Aboriginal communities than among the general population. Today, type 2 diabetes and its complications are the leading cause of death of Aboriginal people

over 40 years of age. The death rate for Aboriginal people with diabetes is double the national average in Canada (Bobet, 1997; Ship, 1998). Human Resources Development Canada (2002) reports that Aboriginal men are twice as likely to die from diabetes complications and Aboriginal women are four times as likely to die from the same conditions.

Diabetes is the leading cause of death for Aboriginal people in Canada. The rate of diabetes among Aboriginal women is double that of Aboriginal men. As well, Aboriginal women are said to have higher rates of gestational diabetes compared to the rest of the general population (Ship, 1998). Young, et al., add that this "substantially increases the risk of diabetes in the next generation" (2000, p.4). The social and economic consequences of the high rate of premature death among Anishinabe women and men will also have significant implications in the present and future family organization and structure (The National Indian & Inuit Community Health Representatives Organization, 2000).

In 1991, The Aboriginal People's Survey identified six key discoveries on the prevalence and distribution of diabetes. They are as follows: (1) Diabetes rates among the Aboriginal population are triple the Canadian average. (2) Type 2 diabetes is prevalent in 5% of the Aboriginal people aged 30-39, and the rates increase with age. (3) Type 2 diabetes rates are highest in the Cree and Anishinabe populations in Ontario, Manitoba, and Saskatchewan. (4) Aboriginal people with diabetes tend to be over 40 and have lower incomes and educational levels than people without diabetes. (5) Aboriginal women have the highest rates of diabetes. (6) There is a higher

prevalence of diabetes on reserves and in rural areas than in urban areas (Bobet, 1997; Ship, 1998; Statistics Canada, 2001).

In response to the last finding, Gregory, et al. (1999) argue that three quarters of the Aboriginal population in Canada live off reserve and generally in urban areas, and researchers have only begun to conduct diabetes studies on them. Researchers are predicting a significant increase in the rates of Aboriginal people with diabetes in the next two decades (Human Resources Development Canada, 2002).

Epidemiological Features of Type 2 Diabetes

There are numerous socio-cultural and biological risk factors that predispose Anishinabe people to type 2 diabetes. The following is a list of risk factors that have been cited from various studies on type 2 diabetes: cultural disruption and rapid lifestyle change, diets high in fat, starches, and sugar, lower levels of physical activity, poverty, obesity, unhealthy living conditions, high levels of psycho-social stress, limited access to adequate health care and support services, over 40 years of age, live on a reserve, heredity/family history (Bruyere & Garro, 2000; Chaddock, 1998; Kewayosh, 1993; Ship, 1998).

Young, et al., state that "Diabetes is a chronic disease with multifactorial causes involving the interactions of genetic susceptibility and environmental factors" (2000, p.4). They attribute dietary acculturation and sedentary lifestyles as the most problematic socio-biological aspects of Aboriginal diabetes. Genetics is considered to play a role in Aboriginal diabetes. Ship states that "Although there is an important genetic component to diabetes, its precise role is unclear" (1998, p.5). Furthermore, Young, et al., say that Aboriginal people need "supportive environments that are

conducive to behavioral change" (2000, p.5). However, before Aboriginal people can gain control over their diabetes, their cultural perspectives on diabetes have to be understood by non-Aboriginal scientists, researchers, and other health specialists so that supportive health strategies are culturally relevant and successful. This is viewed as critical as diabetes complications and its associated costs continue to rise at alarming rates (The National Indian & Inuit Health, 2000). "Evidence indicates that the cost of diabetes and its complications (in adults, 15 years and older) to the Manitoba health care system is over $193 million per year" (Canadian Diabetes Association, 2000, p.2).

Type 2 Diabetes Complications

It is suspected that a high number of Anishinabe grandparents, 40 years and older, are living with many complications from type 2 diabetes. There is extensive literature concerning type 2 diabetes complications, costs, and treatment strategies. Some of the main complications associated with type 2 diabetes are: hypertension, vision problems, non-traumatic limb amputations, end stage renal disease (kidney problems), heart disease and stroke, and nerve damage. Aboriginal people with type 2 diabetes have the highest rates of blindness, kidney disease, and limb amputations and are more likely to die prematurely from their complications (Canadian Diabetes Association, 2000; Chaddock, 1998; Ship, 1998). As a result, Anishinabe people with diabetes and their families often live in a state of fear, helplessness, loss of control and grief as diabetes threatens their physical, mental, emotional and spiritual well being (Cyr, 1998).

Treatment Strategies

Anishinabe people with type 2 diabetes are subject to a number of treatment strategies. The primary emphasis on treatment is maintaining a healthy diet and exercise routine often supplemented with a medication regimen. Research indicates that Anishinabe people do not find the health care system responsive to their needs. Gregory, et al., (1999) found that patients felt rushed during medical visits in which there was minimal interaction with the health care providers. Some patients experienced negative interaction with health professionals who threatened, issued ultimatums, berated, and blamed them for not following instructions. Patients also reported that they were given very little information about their diabetes and were instructed to read pamphlets that they found difficult to read or understand. Research respondents said that they preferred to interact directly with health care providers, as reading was not a comfortable learning style. Bobet says,"These facts should be borne in mind when developing educational material and intervention programs, particularly with reference to reading levels of print materials. This could mean an increased use of audio-visual material and interpersonal contact in health education activities" (1997, p.5).

As type 2 diabetes complications increase, there are a number of different treatment interventions required. Anishinabe grandparents with type 2 diabetes complications may experience spending a substantial amount of time in various treatment programs/facilities to treat their diabetes, such as dialysis, doctors' clinics, hospitalization, in-patient stays, rehabilitation, physiotherapy, counseling, pharmacy visits, and workshops (Diabetes: What it is, 2000). There are also situations where

Anishinabe diabetic patients have to relocate from reserves and rural areas to urban settings in order to access these services. As a result of the many hours required in self-care, many Anishinabe grandparents experience limitations in their daily activities (Cyr, 1998; Young, et al., 2000).

Current treatment strategies are ineffective, as they are not reaching the Aboriginal population with diabetes (Gregory, et al., 1999). Treatment strategies need to be adapted to the culture and social environments of the Anishinabe people. As well, treatment strategies have to take into consideration language barriers, low education, low income or poverty, the lack of cultural competence among health care providers, and institutional discrimination that are currently obstacles to improved health care for Aboriginal people (Bobet, 1997; Ellerby, McKenzie, McKay, Gariepy, & Kaufert, 2000).

Anishinabe Cultural Perspectives on Diabetes

The manner in which the Anishinabe people interpret health and illness is distinct according to their cultural beliefs and values. Gochman, in research on health behavior, discusses how cultural determinants permeate health-related behavior (1988). Gochman uses pattern theory to demonstrate how explicit and implicit patterns of health behaviors are transmitted in various cultures by "symbols; norms; standards for behaviour; ideologies; justifications and rationalizations of selected ways of behaving; patterns of, for, and about behavior in a variety of areas; artifacts and traditional ideas" (1988, p. 243). Within the structural framework of pattern theory there exists distinct subcultural differences associated with ethnicity, religion, and race. Gochman (1988) states that cultural influences reflect perspectives of

health, illness, and disease, and they can be observed in beliefs and behaviors. He adds that the approval and organization of healing practices is referred to as a "health culture" that has meaning and integrity for its members.

In Anishinabe society, elements of Gochman's pattern theory are evident. The cultural knowledge values, ethics, and patterns of behavior regarding health and illness are embedded in the religious belief that good health is a gift from the Creator and it is the individual's responsibility to preserve and maintain it. Affirming the dignity of life is essential (Ellerby, et al., 2000). The medicine wheel's cultural teachings on wholism and balance provide guidance on how to live in peace and harmony with oneself and all other living things (Garro, 1987; Hagey, 1987; Longclaws, 1994). The concept of wholism is a fundamental belief that explains how everything in the universe is interconnected and interdependent and moves in harmony together (Shestowsky, 1993). Longclaws adds that the concept of wholism is understood by the cultural belief "Whatever happened to one happened to all" (1994, p.26).

The concept of balance originates from the cultural ideology that a person has four interwoven parts: body, mind, emotion and spirit. When the four parts are working optimally in respect to self, family, community, and environment, one is thought to be in balance and healthy (Malloch, 1989). Neglect of any of the parts is believed to create an imbalance that causes a decline in health in all areas. Illness is therefore perceived as an imbalance (Shestowsky, 1993).

The Anishinabe cultural belief of diabetes is grounded in the ideology of balance. It is believed that diabetes occurs from a state of physical imbalance.

Anishinabe people attribute the uncontrollable change in diet from traditional foods to processed foods bought in stores as the main source of physical imbalance. Many Anishinabe people acknowledge the harm that over consumption of certain foods and drinks loaded with sugars, fats and chemicals, concurrent with inactivity has had on them (Garro, 1987). The Anishinabe of southern Ontario view the emergence of diabetes as an extension of a "chain of imbalances launched against Nature in the name of modern progress" (Hagey, 1987, p. 115). The Anishinabe also view diabetes as a "White man's disease" that is, incurable but controllable, and episodic in nature (Garro, 1987; Garro, 1989).

The health culture of the Anishinabe involves the use of Western medicine and traditional medicines and health practices. Ellerby, et al. state that "Aboriginal cultures can be identified as premodern in the sense that there is no separation between the self and the universe, between self, family and community or between mind, body and spirit. Thus, healing is not possible without spirituality, nor without relationships to family and community, and to the cosmos" (2000, p. 848). The purpose of the traditional health practices is to try to reestablish balance with the individual through cultural teachings and ceremonies that guide the individual on how to live "a good life."

Hagey states that Anishinabe knowledge of diabetes "does not contain an ideology for conquering it, controlling it or even living with it" (1987, p. 118). This is in contrast to Western medicine that seeks to find a "cure" for the illness. Although diabetes is a relatively new disease, Anishinabe healers have found through shared knowledge with diabetics, some healing practices and properties of plants that are

beneficial in treating symptoms of diabetes. The sweat lodge and fasting have been used widely among the Anishinabe to reduce high blood sugar and psychosocial stress (Hagey, 1987; Young, et al., 2000).

Theoretical Perspectives

There are two frameworks that are appropriate in providing a theoretical understanding of type 2 diabetes in the Anishinabe population. They are ecological theory and the medicine wheel cultural model. These models provide a contextual approach to understanding how people change, adapt and develop in their environment.

Ecological Theory

Ecological theory is an appropriate framework to examine Anishinabe peoples' experience with type 2 diabetes because of its focus on human fit in the environment. Ecological theorists are interested in "the interaction of the environmental and biological variables with social and human variable" (White & Klein, 2002, p. 203). Ecological theory has a long intellectual history rooted in Darwin's evolutionary theory on natural selection and adaptation. White and Klein state that "adaptation is the central concept of ecology" (2002, p. 200). Many of the early conceptual principles of ecological theory are derived from the science of plant ecology. Sociologists then applied the concepts to describe phenomena of spatial arrangements and species dominance in urban studies that became known as population ecology. The focal point of population ecology was to examine how a population adapted to its environment. The work of Mendel, Lewin, and Bronfenbrenner served to integrate a niche or function of ecological theory in the

disciplines of economics, sociology, biology, and demography (White & Klein, 2002).

Lewin emphasized a contextual approach to observing the interaction of the developing person and the family with the environment. His contributions to ecology in turn influenced the work of Bronfenbrenner who developed the ecological theory of human development. Today, this theory is one of the most influential theories used to study the family and its members (White & Klein, 2002).

The contribution of Gregor Mendel's work on genetics and ecological theory is very significant to this study in understanding the transference of diabetes from one generation to the next. By using ecological theory, it can assist us in understanding how Anishinabe people with type 2 diabetes and their families are coping with the disease. Given that ecological theory has made significant progress in the health field by using a multidisciplinary and multilevel intervention approach to understanding health related issues, it can be helpful in providing direction for interventions that may prevent the further spread of this illness.

White and Klein (2002) identify several ecological theoretical assumptions and concepts that are mutually supportive of the Aboriginal ecological worldview. Some of the ecological assumptions that White and Klein discuss are as follows: (1) There is a dual nature of humans as creators of biology and culture. (2) Humans are dependent on their environment for the necessities of life. (3) Human beings are socially dependent on other human beings. (4) The human being's life cycle together with their biological needs for sustenance impose time as both a restraint and

resource. (5) Human interactions are organized in specified space. (6) Human behavior can be understood on various levels (2002, p. 207).

The above assumptions and the concepts of ecosystem and Bronfenbrenner's concept of the family as a "nested ecosystem" are central concepts of ecology that are applicable to this research study. Hawley describes an ecosystem as a subset of a larger environment that "contains the elements of wholeness and the interdependency of parts" (White & Klein, 2002, p. 208). The family is an example of an ecosystem that is connected to other ecosystems. "Bronfenbrenner (1979) suggests that the family is one among many 'nested' ecosystems in which the individual develops and interacts" (White & Klein, 2002, p. 209). The Anishinabe family and their interaction and organization around the issue of diabetes can be examined on four conceptual levels of ecological analysis: the microsystem (family setting), mesosystem (interrelation between two or more microsystems), exosystem (formal and informal social networks), and macrosystem (culture) (Grzywacz & Fuqua, 2000; Longclaws, 1994; White & Klein, 2002).

At the microsystem level, the Anishinabe grandparent with type 2 diabetes is a member of a nested extended family ecosystem (clan based). The Anishinabe grandparent interacts with other nested ecosystems such as family members, friends, neighbors and key members of the health system such as doctors, nurses, physiotherapists, dietitians and traditional medicine people, who all influence health behavior. The Anishinabe grandparent is responsible for his or her health and how it affects others close to them. The Anishinabe grandparent is also dependent on family and community in making health decisions.

In the mesosystem, which is characterized by the interrelations of two or more microsystems, the Anishinabe grandparent may be interacting with work or with the home care system or a community centre to access programs. The Anishinabe grandparent is likely to request assistance from other microsystem sources, for example transportation, to attend to health matters. Grzywacz and Fuqua (2000) state that if there is negative spillover between two microsystems there is greater risk for negative health outcomes.

Exosystems that are not in direct contact with the Anishinabe grandparent that has indirect effects on the person's life are entities such as Health Canada and Indian Affairs. Such parts of the exosystem control health policies, funding and accessibility to health programs and services. Anishinabe people with type 2 diabetes are highly dependent on external institutions that can greatly influence the health of the person with diabetes and their family. For example, cutbacks in home care can create internal family pressures that can lead to stress and family conflict.

The macrosystem provides the cultural context in which lower-ordered systems are governed. At this level, social, economic, and political polices can have a profound influence on Aboriginal people with diabetes. Macrolevel phenomenon such as unemployment, insufficient housing, and poverty are empirically linked to poor health.

In Grzywacz and Fuqua's (2000) work, concepts of social ecology of health are also useful in understanding the health crisis of Anishinabe people with type 2 diabetes. Social ecological principles examine human existence on many levels. When looking at health issues, social ecology researchers examine the psychosocial

environment in order to understand health across the life span (Grzywacz & Fuqua, 2000). They also draw health care providers "attention to dispositions, resources and characteristics of the individual that influence health" (Grzywacz & Fuqua, 2000, p. 2). The ecological principles that are relevant to health and health promotion are: (1) Different dimensions of well being are reciprocally related and linked to diverse conditions in the sociophysical environment. (2) Individual and community well being are contingent upon multiple aspects of the person/population, as well as multiple dimensions of the environment. (3) Health is an outcome of the quality of the person/environment fit. (4) Certain individual or environmental conditions exert a disproportionate amount of influence on health and well being. (5) The physical and social environments are interdependent. (6) A comprehensive understanding of health results from multidisciplinary approaches (Grzywacz & Fuqua, 2000, p.2).

The transference of ecological concepts and assumptions of person-environment adaptation in relation to health issues offers great potential for the design of culturally relevant treatment strategies for Anishinabe people with type 2 diabetes. If researchers and health officials understand the Anishinabe cultural perspective of health and illness and the effects that cultural barriers have on the issues of health and treatment compliance, it could lessen the costs of ineffective treatment regimens and provide more appropriate attainable treatment goals.

The Medicine Wheel Cultural Framework

The medicine wheel philosophy when applied in its cultural theoretical context conveys how Anishinabe people interpret the world, health and illness. The medicine wheel is an ancient philosophy, a scientific tool and a "cultural system of

scientific thought evolved from unique perceptual orientations to natural reality (Cajete, 1999, p. 37). The medicine wheel is "a rational ordered system of theory and investigation" that moves beyond the boundaries of objective measure (Cajete, 1999, p.81). The medicine wheel philosophy integrates spirituality as a core component to understanding phenomena of any kind. The medicine wheel is holistic and inclusive in its application to understanding human beings, the world and the cosmos (Hart, 2002). Although it does not fit the Western scientific definition of a theory, Cajete states that "Attempts to define indigenous science, which is by its nature alive, dynamic and ever changing through generations, fall short, as this science is a high-context inclusive system of knowledge" (1999, p.82).

The medicine wheel does have explanatory power in regards to health and illness and family relationships. The concepts that are central to the medicine wheel cultural framework are immanence (a belief in and respect for unseen powers), balance, interconnectedness, holism, and self-in-relation. The concepts all involve systems of relationships to the land, people, plants, animals, and the cosmos (Cajete, 1999; Graveline, 1998).

The medicine wheel is a real and symbolic representation of a complex cultural, religious and spiritual philosophy that is used to explain how Anishinabe people are interconnected to the universe and all living things (Meadows, 1990). The medicine wheel is used to teach and practice the Aboriginal worldview. Longclaws states that the Anishinabe elders define worldview as "the interconnection among all beings and forces existing on physical and spiritual worlds" (1994, p.26). The Anishinabe worldview is made up of traditional laws, teachings, ceremonies, rituals,

values and ethics on how to live in health, peace, harmony and balance with oneself and all of creation. It is a guide to living, that when followed, can lead to self-discovery, self-mastery, personal fulfillment and good health (Cianci & Nadon, 1987; Meadows, 1990).

The four directional domains of the medicine wheel signify a holistic approach to life that teaches people how to balance the mental, spiritual, emotional, and physical parts of their being. When a person can walk in balance in these four directions they are considered to be a whole person (Cianci & Nadon, 1987). The medicine wheel teaches the Anishinabe that balance is achieved by walking in these four directions and getting a full understanding of the different medicines (healing power, visions, natural elements) and gifts (knowledge, wisdom) that can be attained in each domain. The goal is to exist in the center of the medicine wheel and to walk in balance with all that the circle represents. The circle, which represents our earth and one's lifetime, teaches the Anishinabe that everything is interconnected, cyclical and unending. Along with oral teachings, traditional ceremonies reinforce cultural knowledge and provide guidance and strength to individuals who are trying to center themselves. Ceremonies are also performed to cleanse and purify the body, and to heal the mind, heart, and spirit (Wilson, 1994).

The medicine wheel teachings of the four directions are passed orally from elders to younger people with a strong religious and spiritual orientation. The elders use their traditional knowledge and skills to guide, protect, locate illness and heal others. Anishinabe elders are often asked to help individuals learn how to live with diabetes. According to Longclaws (1994) it is traditionally believed that by

practicing medicine wheel teachings and ceremonies, one is protected from evil forces that could lead one astray from this way of life. Evil forces are believed to exist in the physical and spiritual worlds. Evil is considered to be manifested in curses of bad medicine and more recently in substances like alcohol and drugs. It is also believed that if one adopts the values of materialism, dishonesty, greed and jealousy, they will prevent the individual from achieving balance or centeredness.

It is within this cultural context that health and illness is rationalized. The Anishinabe generally recognize that attaining balance, in a world that has impeded their traditional lifeways, is more difficult to achieve than ever before. For many Anishinabe people living off reserve it is difficult to gain access to traditional medicine people, folk medicines, healing practices, and a cultural/spiritual support system when they are ill. As well, Anishinabe people know that their socioeconomic conditions are not conducive to good health and well being; however, many feel powerless to change their personal and family situations.

As a result, many Anishinabe people with type 2 diabetes view it as a progressive disease that has a "natural course" that defies control from health care providers and the Anishinabe themselves (Garro, 1987; Gregory, et al., 1999). Many Anishinabe acknowledge that diabetes is "part of a complex set of personal, social, cultural, and historical interactions" and that there are no easy solutions (Gregory, et al., 1999, p.111). Many Anishinabe people believe that they have little means of controlling their life/health situations and accept that diabetes will likely lead to premature death. Young states that "When the Western physician informs the Native American patient that he or she has diabetes, the physician also tells them that the

disease is chronic, incurable, and progressive. From the perspective of the health belief system of some Indians, this is a sentence of death. The patient feels not only that the disease is beyond his/her control, but that all efforts to follow a strict medical regimen to control this disease are useless" (1987, p.27).

Implications

Type 2 diabetes in the Anishinabe population poses a number of important implications for individuals and families. Currently, type 2 diabetes is threatening the quality of life and the life course development of many Anishinabe grandparents. If current scientific predictions hold true for the increased spread of the disease, Anishinabe families could be facing a greater health crisis if culturally relevant health solutions are not implemented and the living conditions for Anishinabe grandparents do not improve.

The absence of Anishinabe grandparents in the lives of younger generations also has critical implications for cultural preservation. Anishinabe grandparents are the transmitters of culture and without them, the cultural identity of the people would be challenged similarly to historical times when new diseases like smallpox were rampant and many people died (Young, 1988). Without a critical mass of grandparents children, parents, and other adults will not receive traditional instruction of their identity, gender roles and child rearing practices. Other cultural and religious practices that require daily instruction on traditional knowledge, morality, values and the teaching of skills will be lost to future generations.

Grandparenting in Canada

Canadian grandparents are taking more active roles caring for grandchildren under the age of 14. According to a 2001 census report on grandparenting, Manitoba has the second highest number of young children whose grandparents care for them. The statistics for Manitoba show that 2,045 grandchildren or 0.9 percent of children are being raised in "skip generation" households where the parent is absent from the home. The grandparents providing care are primarily women, and just under half are retired. Many grandparents who are enjoying good health are able to raise grandchildren in their own homes. Statistics for Canada reveal that over half of the grandparents surveyed live in multigenerational homes shared with their adult children and grandchildren. This practice is more common in Aboriginal and immigrant cultures where extended family cohabitation is part of the culture (Sanders, 2003).

The literature indicates that in Canada the trend of grandparents assuming more childcare responsibilities is growing (Rosenthal & Gladstone, 2000). The reasons for its growth are varied and are said to change over time. Some of the reasons for this trend are family problems, children being neglected, children attending school in grandparents' area, and financial stress in single parent homes. Grandparents often act as a 'buffer' in families experiencing problems. They help to stabilize the family by trying to help maintain the family and keep it together. Grandparents are also believed to benefit from such living arrangements when they need emotional, physical and financial support (Rosenthal & Gladstone, 2000).

Anishinabe grandparents with type 2 diabetes benefit from grandparent support as well. In addition to the above benefits they also find this type of living arrangement natural and spiritually uplifting (Alphonso, 2003). They also view this type of living arrangement as an important function in which they can promote and maintain the Anishinabe family life, language, culture, values, and traditional knowledge and practices. If Anishinabe grandparents with type 2 diabetes do not have good health it is difficult for them to provide support.

Literature Gap

The purpose of this thesis was to increase our knowledge of how Anishinabe grandparents diagnosed with type 2 diabetes view their roles, responsibilities and relationships with grandchildren. There is an extensive body of literature on the changing roles of grandparents in the dominant culture; however, there is very little written information pertaining to the experiences of Anishinabe grandparents. The goal of this study was to contribute to literature on Aboriginal people and to increase understanding of the multitude of quality of life issues facing Anishinabe grandparents as they try to maintain their traditional position in the family system.

Summary

This literature review examined the Anishinabe family system in pre-colonial and colonial times. It highlighted some of the historical factors that led to the rapid transformation of the traditional Anishinabe lifestyle. It also discussed some of the socio-economic, political, and cultural conditions that have been linked to the epidemic of type 2 diabetes in the Anishinabe population. Type 2 diabetes and its varied determinants were explored to gain an understanding of the magnitude of the

problem. The identification of epidemiological features and risk factors highlighted the many disparities that contribute to the high prevalence of diabetes in the Anishinabe population.

Ecological theory and the medicine wheel framework are helpful models to use in this research to gain a broader perspective on a complex multidimensional multi-level problem. The two frameworks provide insight into the fit between humans and the environment. The concepts and assumptions of both models are complementary to each other and useful in explaining the two cultural perspectives on the issue of diabetes. They also provided an opportunity to explore how macro level institutions can intervene in meaningful ways to improve the life expectancy of Aboriginal people living with type 2 diabetes.

This review of literature demonstrates how socio-economic factors, for example, are empirically linked to the poor health status of Anishinabe people and the chronic disease of type 2 diabetes. This suggests that type 2 diabetes will continue to escalate until socio-economic inequities are reduced through public policy (Abonyi, 2001; Bobet, 1997). It is also important that health practitioners and policy makers understand the Anishinabe health behavior and health culture so that they come together with Aboriginal people and work on solutions together.

Anishinabe grandparents with type 2 diabetes face a diminished quality of life if they do not take steps to control their diabetes. If there is poor control over the diabetes and it is advanced, it may lead to complications that may require extensive treatment regimens. This could result in Anishinabe grandparents needing to have access to treatment several times a week which would restrict family activities. Some

grandparents with type 2 diabetes are placed in institutional facilities away from family and community which decreases contact with significant people. Many Anishinabe grandparents are also experiencing a decline in their traditional roles in the family system due to their declining health (Ship, 1998). There is currently very little literature addressing the social implications of type 2 diabetes on the day to day interactions of family members. The literature on type 2 diabetes leads one to believe that grandparents spend less time with grandchildren as treatment regimens take priority over family matters. Hence this study explored the traditional roles of Anishinabe grandparents and tried to determine if they are performing the grandparent role differently from the ways in which they were grandparented. The research also examined the grandparents' perceptions of how diabetes is affecting their lives and relationships with grandchildren and analyzed the impact that type 2 diabetes is having on their ability to perform traditional child rearing roles.

CHAPTER 3: METHODOLOGY

For the purpose of this study, it became apparent that I had to collect data from participants directly, as no existing data set would allow secondary analysis. Since little is known about the effects of diabetes on grandparenting a qualitative method is the most desirable as it yields a great deal of depth on a topic. The research methodology incorporated the following steps: gaining ethical approval, selecting participants, designing a questionnaire, reviewing literature, interviewing participants, directly observing participants, tape recording data, transcribing data, analyzing data and reporting findings. The qualitative methodologies that enabled me to address the goal and objectives of this study use ethnography and oral tradition.

Ethnographic Research Methodology

Ethnography is a qualitative research methodology originating from the disciplines of anthropology, sociology, education and cognitive psychology. Ethnography is defined as a naturalistic inquiry approach that seeks to understand human behavior from the participants' own points of view (Bishop, 1999; Schensul, et al., 1999). Ethnographers attempt to understand and describe the participants' belief systems, cultural practices, social events, rituals, ways of thinking and the meaning people give to these patterns. Schensul and colleages describe ethnography as a "human endeavour" where "the ethnographer's principal database is amassed in the course of human interaction..." (1999, p. viii). Bishop states that "Ethnographic inquiry represents a researcher's grounding in a different set of belief's – naturalistic, holistic, subjective beliefs – about empirical research." (1999, p. 5). Fagg (1970) and Bishop (1999) both concur that

ethnographic research is hard to define because of general concepts involved such as culture, language, and symbol.

Ethnographic research has come under much criticism from the quantitative research community because it is phenomenological in nature and involves participant observation inquiry that is subjective (Bishop, 1999). Johnson (1990) cites Geertz (1973) as describing ethnographic research as "thick description" (p. 11) or as Van Maanen said in 1988 as "an interpretive act" (p. 11). Furthermore, some social scientists view ethnographic research more as a strategy than a method because of the lack of explicit and transferable procedures for conducting ethnographic research (Johnson, 1990).

The process of ethnographic research involves the researcher selecting participants with specific patterns of behavior that the researcher observes and documents. According to Schensul, et al., (1999) "the researcher is the primary tool for collecting primary data." (p.viii). The methodology strategies or tools used to collect and analyze data come from field research such as: direct observation; field notes; face to face transcribed interviews; survey research; "audiovisual recording; and mapping the networks, times and places in which human interactions occur." (p.viii). Schensul, et al. (1999) state that ethnographers select such methods or tools to answer the following questions: "What's happening in this setting?" "Who is engaging in what kind of activities?" and "Why are they doing what they are doing?" (p.ix).

Advantages and Disadvantages of Ethnographic Research Methodology

There are several advantages and disadvantages of applied ethnographic research methodology. The advantages are as follows: (1) The researcher can get an understanding of an individual's perceptions and feelings about a social event or

experience. (2) "It can be used to identify and solve complex social problems, especially those not readily amenable to traditional quantitative or experimental research methods alone" (Schensul, et al., 1999, p.vii). (3) By using electronic recording devices, ethnographers have a greater capacity to observe and listen by creating a more complete and permanent record of events, behavior and speech (Schensul, et al., 1999). (4) "By 'getting close,' ethnographers provide a texture, an immediacy, and a depth of understanding that cannot be attained through research strategies that keep the social world at arm's length" (Grills, 1998, p. 16).

The disadvantages of the ethnographic method are as follows: (1) It lacks quantitative methods. (2) Researchers "engage 'respondents' in relationships that are relatively short-lived and emotionally inconsequential for both parties" (Johnson, 1990, p. 5). (3) Borman's et al.'s (1986) criticism of qualitative methods, particularly ethnography, "is that it is too subjective, too value laden, not replicable, not generalizable, trivial in its conclusions, lacking internal validity, not empirical, neither rigorous nor systematic (i.e., unscientific), and it doesn't prove anything" (Johnson, 1999, p. 11). (4) Ethnographic research is seen as a "trial by fire approach" (Johnson, 1999, p. 13).

Researchers Who Have Used Ethnographic Research Methodology

Researchers in anthropology and sociology have used ethnographic research methodology longer than the other disciplines previously mentioned (Bishop, 1999). Ethnographic research methods have been used to study individuals, couples, families, groups, organizations and communities. Schensul, et al. (1999) state, "It is designed for educators; service professionals; professors of applied students in the fields of teaching,

social and health services, communications, engineering, and business; and students working in applied field settings" (p.viii). One example of how ethnographic research is used is illustrated by Fagg (1970), where he subjectively selects eighty wooden figures and examines the spiritual values of tribes through symbolism and sculpture. Bishop (1999) also adds that ethnographic research is "textualized" through physical artifacts. Another example is Schensul, et al.'s (1999) application of ethnographic research using guidelines and case studies to demonstrate how ethnographers have used ethnographic data to plan public programs and influence public policy.

Use of Ethnographic Research Methods in the Present Study

This research applied ethnographic research methodology to get the "insider views" from Anishinabe grandparents about their roles and responsibilities in child rearing. Since Anishinabe grandparents are an invaluable source of historical and cultural knowledge about Anishinabe family life, I used the research method of face-to-face interview to elicit information. This data collection allowed me to get the participants' personal views, feelings, cultural beliefs, cultural practices, rituals and values that describe the close relationship between Anishinabe grandparents and grandchildren. By triangulating methods of data collection the same phenomena many be viewed in different ways, adding to the depth of understanding.

This information could be a valuable source to academics, educators, social service professionals, health care professionals and family life educators who are interested in getting a current description of Anishinabe family organization. The information I collected using ethnographic research methods included historical knowledge about the Anishinabe extended family system and description of the traditional roles and

responsibilities of grandmothers and grandfathers. Information was obtained on the current roles and responsibilities that Anishinabe grandparents perform in child rearing. The grandparents were asked whether they saw their roles and responsibilities as different or similar to their grandparents. This research also collected information on whether the grandparenting roles and responsibilities are negatively affected by the grandparent's health status.

Ethnographic methodology and oral traditions utilize some concepts and methods that are similar in design such as interviewing and taping research participants. In both of these methodologies the aim is to obtain "insider views" about the research topic.

Oral History Research Methodology

Oral history has been the primary means that many cultures around the world have transmitted cultural knowledge and skills from one generation to the next. Hart (1995) and Reimer, Mattison and Specht (1984) state that oral history has been around for a very long time and was one of the earliest methods of recording and preserving history. Hoops (1979) states that oral history's origin is in speech. It also includes a range of activities such as songs, interviews, speeches and plays that serve to pass knowledge through the oral tradition. Hart further adds that "The skills for survival such as hunting, building houses, making clothes, tools, medicine and religious practices were taught by telling and showing one another how to do these things" (1995, p. 3).

The oral tradition has been defined as a research methodology that involves interviewing and tape recording people to learn about their personal recollections, life, culture, and history from first hand knowledge (Baum, 1995; Hart, 1995; Reimer, et al., 1984). Oral tradition methodology is qualitative research that has been criticized for its

subjective nature. Historians and other researchers have questioned the reliability, validity and usefulness of oral tradition methodology. Reimer, et al., (1984) state that this criticism has come from difficulties verifying the accuracy of oral traditions with written records. Some critics also question the fact that memory distortions do occur in interview situations that flaw research data.

Advantages and Disadvantages of Using Oral History Methodology

Oral history methodology has a number of advantages and disadvantages. The advantages are as follows: (1) The researcher actively participates in creating the oral document (Hoops, 1979). (2) Oral history recognizes valuable life contributions that the participants have made to the family, community, and society. The grandparents have valuable life experience and traditional teachings about their roles and responsibilities in the family, particularly with children, which they gave to the researcher. (3) "The strength of oral history is not so much in gathering factual information as in the expression of attitudes, feelings, impressions, the anecdotes that bring history to life." (Reimer, et al., 1984, p. 2).

The disadvantages of using oral history methodology are as follows: (1) It could be unreliable if participants' memories become distorted (Reimer, 1984). (2) The researcher "may consciously or unconsciously fabricate the document and make it say what he wants it to say" (Hoops, 1979, p. 12).

Researchers Who Have Used Oral History Methodology

Oral history methodology has been widely used by researchers in disciplines such as history, anthropology, sociology, family social science, social work, ethnology, linguistics, and education. Oral history has also been practiced by cultural groups and

community groups (Hart, 1995). Reimer, et al., (1984) discuss the strength and flexibility of oral history methodology by illustrating the many uses of oral history interviews. They state that oral tradition interviews are a recognized methodology that has "been used for scholarly research, for the writing of popular history, in radio broadcasts, in television and in films, in genealogical research, in slide/tape presentation and museum displays, in education, as a source material for drama, poetry and fiction, and as therapy for the aged" (p. 55).

Use of Oral History Methodology in this Research

In this study the researcher interviewed and tape-recorded five Anishinabe grandmothers and five grandfathers who have type 2 diabetes, to find out if their health condition(s) affect their relationships with grandchildren. A guided interview was used to gather their views and life experiences (see Appendix D). The interview was designed to begin with a conversation about the researcher, her ties to the Anishinabe community, and her interest in grandparenting, to set the stage for the questions to be asked. Such personal sharing is considered polite in the culture and is necessary to establish rapport. The questions first explored personal history, then family of origin, and finally grandparenting.

Informed Consent Procedures

Informed consent procedures were approved for this research by the Joint Research Ethics Board, University of Manitoba, prior to starting data collection. The researcher and her advisor submitted a plan to ensure that participants would be fully informed of procedures in advance of the interview. Further participants also signed an approved statement of Informed Consent. Approval was granted on February 9, 2004.

Participant Selection

The research involved for this study required face to face interviews with Anishinabe grandparents who have type 2 diabetes and have grandchildren, and live in Winnipeg, Manitoba. An advertisement was aired by a local First Nations radio station in search of interviewees for the study (see Appendix A). Participants were also sought by means of a snowball sample where the researcher utilized personal and professional contacts in the Aboriginal community. The participants were given a letter explaining the research project and what they would be asked to do. The researcher then telephoned the participants to arrange an interview. At the conclusion of the study, participants were sent a letter summarizing some of the main findings from the research and to acknowledge their input in the research.

I used the oral tradition to collect personal information about the participants, family history and cultural knowledge about child rearing practices. Using this method, grandparents provided information about historical events such as residential school and the child welfare system that have affected and changed their roles and responsibilities in the family and in child rearing. I expected that they would talk about their grandparents and present some comparisons with their own experiences with grandchildren. In doing so I believed that they would also talk about their views on how cultural values and traditions have changed and how these changes affect their position within the family. It was expected that they would also share information on their personal feelings about their health status and discuss any factors that may be hampering their ability to fulfill their traditional roles and responsibilities with grandchildren.

Participants for this research study were found through a radio advertisement and a snowball sample (see Appendix A). A letter to obtain informed consent was given to each participant explaining the research and their role in it (see Appendix B). Prior to the interview each participant was asked to complete a written consent form (see Appendix C). The researcher informed the participant of their right to privacy. Participants were informed of their right to refuse to answer any question at any time, ask for clarification for any question, end the interview at any time, or withdraw their consent at any time.

The data for the study were collected from face to face guided interviews that were tape recorded along with some hand written notes by the researcher (see Appendix D). The interviews were around one and one-half hours in length. The participants were given an option of receiving a summary of the findings (see Appendix E).

The taped interviews were transcribed verbatim, reviewed and analyzed by the researcher for ideas, concepts and themes. The data were then coded and categorized for further analysis. The researcher, her advisor, and a co-worker who is a grandmother with diabetes discussed and agreed on the codes. The name of the participant did not appear in the research findings and the tapes were discreetly coded to protect the identity of the participant. The tapes were kept in a locked cabinet. When the information was compiled in document form the tapes were destroyed.

CHAPTER 4: DATA COLLECTION

The data collection phase started on February 24, 2004 and was completed on December 10, 2004. The inclusion criteria were as follows: (1) Anishinabe (Ojibway) descent, (2) 50 years of age or older, (3) English-speaking (4) diagnosed with type 2 diabetes, (5) a grandparent, and (6) a resident of Winnipeg, Manitoba or surrounding area.

The search for participants began by the researcher informally asking family, friends, fellow students and former colleagues if they were aware of any people fitting the criteria. Thirteen people were approached and 10 were interviewed. Three people did not meet the criteria, as they did not have type 2 diabetes. This process continued until December 5, 2004. The first interview took place on April 26, 2004 and the last one occurred on December 10, 2004.

In the nine-month period I got a cell phone specifically for interested persons to contact me. A number of other initiatives were undertaken to recruit interviewees during this time period as well. The first strategy to recruit participants involved a media advertisement on a local Aboriginal radio station (see Appendix A). The radio station's only stipulation was that I create a thirty-second script and read it myself. The radio station agreed to air it several times a day for three weeks. The second strategy was to recruit via organizations, including the Native Aboriginal Diabetes Association, Dakota Ojibway Tribal Health, Aboriginal Health & Wellness Centre, Health Science Centre-Manitoba Renal Program, and Keekinan Centre (Aboriginal Senior Centre). In-person meetings with representatives at these facilities followed by telephone calls and e-mails took place to enlist their help in the recruiting process. In addition to this, posters were displayed at the following sites: Neechi Foods, Indian and Metis Friendship Centre, Keekinan Centre, Aboriginal Health and Wellness

Centre, and the Health Science Centre- Manitoba Renal Program. These efforts resulted in one respondent. The other nine respondents were obtained using a snowball sampling method. None of the respondents were couples or related to each other; however, one respondent was a distant cousin through marriage to the researcher.

The interview questions were posed in a specific order to respect the cultural mores of relationship building among the Anishinabe people. The questions were arranged to communicate at a general and individual level first before asking questions about their immediate and extended family. In the Anishinabe culture relationship building begins by sharing information, particularly locating self and family in the context of community and ancestral roots. Whether a person speaks the Anishinabe language is another important aspect in forming a relationship.

In Anishinabe culture, as well as in other First Nations, the notions of diplomacy and reciprocity are integral in developing relationships. Therefore it is customary to offer gift(s) in return for something needed or wanted. For the purpose of this study I asked respondents to share their time, information about themselves, and any traditional or cultural knowledge they had. In preparation for gathering information tobacco was purchased as an offering to respondents for sharing their personal stories and traditional knowledge. Prior to contact with respondents I asked the referral source if the respondent had Anishinabe religious values or other religious beliefs. In the case of one respondent tobacco was not offered because of the respondent's religious faith. Some respondents accepted tobacco while others declined it. All of the respondents were given a material gift worth $10 and a $25 dollar honorarium for their contribution.

The majority of the respondents lived in the city of Winnipeg. Two respondents lived on the outskirts of Winnipeg, and one of these respondents was in the process of moving into the city. Four of the respondents were interviewed in their homes, four were interviewed at their work offices, one was interviewed in the interviewer's vehicle, and one was interviewed at the home of the interviewer. Each interview took around one and a half-hours to complete.

Each respondent was contacted by telephone and given a description of the criteria and a brief summary of the study. After agreeing to an interview a meeting was arranged at a mutually agreeable date, location, and time. Prior to the start of an interview, a tobacco offering was made, and with the exception of two individuals who declined the tobacco, all of the gifts and honoraria were given to the respondents after the interview. In the preliminary phase of the interview the interviewee was given a Written Consent Form (see Appendix C) to sign as well as a form to specify whether they would like to receive a two-page summary of the research findings (see Appendix E). All 10 respondents completed both forms and all of them indicated that they would like to have a research summary mailed to them.

The interviewer asked for the respondent's permission to tape the interview in addition to taking hand written notes. All of the respondents were in agreement with this procedure. Before starting the interview, some of the respondents questioned the types of questions they would be asked. When questions occurred the interviewer read the questionnaire subheadings to the respondents to give them an overview. In one situation the respondent asked to read the questionnaire before proceeding with the interview. The interviews did not start until the interviewer received full confirmation from the respondent to proceed.

Description of Respondents

Five Anishinabe grandmothers and five grandfathers were interviewed in the study. Their average age was 58.2 years. The youngest was 51 and the oldest was 65. The average age of the grandmothers was 58.4 years and the average age of the grandfathers was 58.0 years. Six of the respondents were married, one was separated, one was single, one was divorced, and one was a widower.

Eight respondents were raised on First Nation's reserves in Manitoba; one grew up in Winnipeg, and one in rural Manitoba. All of the respondents remember interacting with one or both sets of grandparents. Some respondents had minimal contact with grandparents, and some had quite a lot of bonding time and influence from their grandparents.

The 10 respondents had a total of 41 children among them and a combined total of 115 grandchildren. The grandchildren range in age from one month to 25 years old. Five of the grandchildren live in two provinces outside of Manitoba. Approximately 46 grandchildren live in Winnipeg, and 64 grandchildren live in rural Manitoba, primarily in First Nation's communities.

One female respondent reported sharing her home with her son and two grandchildren. One male respondent had his four year old grandchild living in his home, and one male respondent was sharing his home with a daughter, son-in-law and two granddaughters. The rest of the respondents did not live with their grandchildren. One respondent who does not live with her grandchildren has daily contact with them, and five other respondents see their grandchildren one to four times a month. One respondent sees her grandchildren infrequently. Two of the respondents have grandchildren outside of Manitoba who they see once a year. Two of the respondents had foster children living in their homes.

Five respondents did not complete high school, and five completed high school and had post secondary education. Four respondents attended residential schools in Manitoba. One respondent spent one year in a residential school, a second respondent spent two years at a residential school, a third respondent attended three different residential schools in four and a half years, and a fourth respondent attended four different residential schools in 11 years. One of the respondents later worked at two residential schools in Manitoba and one in Saskatchewan.

Half of the respondents worked on a full time basis. One respondent worked part time, three did not work, and one respondent was retired. Of the three respondents that did not work, two reported their health status interfered with being able to work.

Seven of the respondents indicated that they owned their homes. Two respondents were renting apartments, and one respondent who was interviewed in a house did not disclose whether she owned it or rented it.

Length of diabetes

Respondent's had diabetes from 2.5 to 24 years. Only two respondents had been diagnosed with type 2 diabetes less than five years ago. The rest have had diabetes for 11 to 24 years. Of the 10 people interviewed, 9 had diabetes in their immediate family. Seven respondents had one or two parents who had diabetes. Of the parents who had diabetes six were mothers and two were fathers and the majority died from diabetes complications. Only two respondents had a grandparent who had diabetes. Seven respondents had a brother with diabetes and four respondents had a sister with diabetes. Two respondents reported having an aunt or uncle with diabetes. Only one respondent disclosed having two children with type 2 diabetes. None of the respondents revealed having grandchildren with diabetes.

Eight respondents said that they are taking hypoglycemics to manage their diabetes. Of the eight, three respondents indicated that they are taking pills but they did not say what they are taking. The most commonly used diabetes medication is Metformin (Glucophage) that is used by four of the respondents (Canadian Diabetes Association, 2003). One of the four also uses two other diabetes pills. Another respondent is taking insulin as well as two different types of diabetes pills. Two respondents did not state whether they are taking diabetes medication.

Five respondents have co-morbidity health issues. Several respondents reported having mood swings that they associated with their diabetes condition, but none had severe complications such as amputations or blindness.

CHAPTER 5: RESULTS

Themes

This section presents the perceptions of respondents who are living with type 2 diabetes regarding how it affects their relationships with grandchildren. The findings were organized in three theme classifications: grandparenting, health and education.

Grandparenting: How Respondents Learned To Be Grandparents

Most of the respondents believe that they learned how to be grandparents through a "natural and instinctive" life process. In this life process socio-cultural influences contributed greatly to their individual and family development. By being immersed in the Anishinabe culture, many of the respondents stated that grandparents influenced them from an early age. As very young children, the respondents "watched, listened, and learned" customs and values of Anishinabe life from their parents, grandparents, and other adults around them. The respondents said that they talked to their grandparents and paid attention to what their grandparents said and did. Several of the respondents talked about the love and respect they had for their grandparent(s). Grandparents helped many of the respondents learn their roles as children and how to do tasks and help others. Respondents who did not have their biological grandparents near them while they were growing up indicated that they "picked up things along the way from other people." One respondent who had little grandparent and male influence in his life said that he failed as a father, and he read books to help him prepare for his role as a grandfather. One other respondent who spent most of his childhood in residential schools said that nobody prepared him for adulthood and as a result he too "failed as a father." He said, "But I got my second chance now with my grandchildren and I call myself a parent again."

Role of Cultural Teachings

Many of the respondents spoke fondly of their grandparents and about the cultural teachings their grandparents gave to them to prepare them for life. The traditional teachings came to them in several different ways. Several of the respondents' earliest memories of their grandparents involved close social interaction and role modeling. One respondent went with her grandmother to pick roots and berries and then watched as they were boiled to make medicine. Other respondents spoke about how they were taught as children to respect medicine people and the powers (good and bad) of traditional medicine. Cultural teachings were also significant in preparing some respondents for their positions in the family and their roles as grandparents.

As children, respondents were taught the cultural teachings through an oral tradition and participation in traditional ceremonies. Respondents recalled time spent with grandparents and other elders when they were told stories about how to respect people and all of creation. Several respondents were taught the Seven Sacred Teachings (wisdom, love, respect, bravery, honesty, humility, and truth) and how to apply them to family relationships. One respondent received many medicine wheel teachings from various elders about the individual's role throughout the life span as well as the role of grandparent. In addition to this, as children, respondents attended traditional ceremonies such as the pow wow, sweat lodge, naming ceremony, teaching lodge, and pipe ceremony. Some respondents received cultural teachings from both the Anishinabe religion and the Christian religion that helped prepare them for their roles as grandparents. By far, the most influential persons who helped prepare respondents for

their roles as grandparent were their own grandparents, parents and extended family members.

Over half of the respondents experienced personal hardships, such as being separated from family in childhood, attending residential school, alcohol addiction, family dysfunction, marriage and family breakdown. These acted as turning points in their lives to help prepare them or improve on their roles as grandparents. One respondent viewed diabetes as an impetus to "do things better."

Activities Respondents Did with Their Grandparents

There were many different types of activities that respondents recalled doing with their grandparents. Some of the activities involved learning cultural knowledge and values. One such activity was story telling. Respondents recalled stories and legends that grandparents passed on to teach them about Anishinabe morals, values, and reverence for all living things and the land. One respondent stated,

> ...one story I remember is that you never did anything or hand gestures to the moon, the stars, the things in the heavens...The story was this boy one time went to fetch water with a little pail. This of course was in the wilderness and, ah, as he was walking he started to make finger gestures to the moon, and the moon took this little boy, and they used to tell us to look at the moon and we would have our eyes fixed on the moon and there's some sort of an image on the moon that looks like a little boy holding a pail, and they always told us that's what happened to the boy.

Such stories and legends reinforced the Anishinabe value system of "how to respect things given to us."

Several respondents recalled being nurtured and cared for differently by their grandparents. They believed that their grandparents were not as strict as their parents were. Their grandparents had more time to teach them about their place in time and about things that would happen in the future. Respondents believed that they spent a lot of time with grandparents, visiting with them, talking to them, listening to the radio together, going on walks together and doing things together, because "we had that respect for our grandparents." One respondent added that in his days grandparents "had some control on their grandchildren."

A lot of the activities that grandparents did with grandchildren were connected to teaching the children life skills and how to survive from the land. Respondents remembered grandparents teaching them respect for the land and about nature. Activities were also gender specific. Male respondents were taught skills such as hunting, going on the trap line, trapping, setting traps and snares, fishing, setting fishing nets, drying fish, and doing other outdoor chores like cleaning the barn. Female respondents were taught how to cook, sew, do beadwork, make moccasins, pick berries, and preserve fruits and vegetables. There were some activities that grandparents did with both genders such as gardening, camping, going to church, going to traditional ceremonies, walking, and going on picnics, shopping, and going to bingo. Many of the respondents felt cared for and loved by their grandparents and they appreciated the advice they got on how to do certain things.

Many reported having fun doing things with their grandparents. Doing chores together was viewed as quite pleasurable by several of the respondents even though some of the chores required intensive labor. Some of the respondents stated that as they got

older they came to understand that their grandparents were in fact teaching them lifeskills and preparing them for their future. One respondent summed up this sentiment by saying, "You became more adept at your lifeskills as a result of your activities with your grandparents and you weren't aware of it of course, it was fun for you, you know, because you were with your grandparents, and you were learning to do things."

Comparing Similarities in Grandparenting

Similarly, respondents felt that teaching their grandchildren was one of their most important tasks. They are teaching their grandchildren lessons on morality, values and respect. Some of the respondents are using the oral tradition of story telling to teach cultural beliefs and how to live a respectful life. For example, when one of the respondents has his grandchildren visiting he teaches them how to smudge with sweetgrass in the morning and at night. Another respondent said "...I teach them how to respect things. Make sure they respect the elders or respect the clothing their parents buy for them...."

Some respondents who had received emotional nurturing from their grandparents expressed similar emotional commitment toward their grandchildren. These respondents believe that the best gift that they can give to their grandchildren is their time, and to be able to talk to them and listen to them. One grandmother said "I was very close to my grandmother – my kookum and very close to my mishoom so... because I was so close to them and because I loved them so much... I feel the same for my grandchildren. It's important that I love them, that I influence them." These grandparents also expressed a desire to nurture the potential they see in their grandchildren. One grandmother said,

> They are different to my children, my own children. I'm freer

> with them. I see them having so much potential, they have so much to learn and so much to give...so that's I guess the kind of things that my grandparents did for me. They believed in me and I believed in them.

Respondents who had more interaction with their grandparents when they were young found it easier to play with grandchildren and to do things with them like gardening and taking them shopping. For example, one grandmother who was influenced by her grandmother, a medicine woman, said that she carried on the tradition of wrapping her grandchildren and keeping the baby's feet in moccasins. She also used traditional medicine on her grandchildren when they were teething.

The respondents who had fewer interactions with their grandparents when they were growing up found it more difficult forming interactive relationships with their grandchildren. Some respondents who attended residential school did not feel that they were doing similar things with grandchildren that their grandparents did with them. They felt that their separation from their family deprived them of family bonding, role modeling, and learning about cultural traditions. One respondent did not know his grandparents that well to comment and two others said that society has changed too much that they grandparent "completely different" than their grandparents did.

Comparing Differences in Grandparenting

Some respondents did not spend much time with their grandparents when they were young. They are trying to pay attention to their grandchildren by spending time with them, showing more affection, talking, playing, and reading to them. Some respondents who did not have strong connections with family stated that they had difficulty forming

relationships with their spouses and children. Respondents who talked about failing as parents came from homes that lacked parental involvement. Two respondents had problems with alcohol addiction, and when they quit drinking they felt that the grandchildren gave them a second chance to "parent all over again." Some of these respondents learned their Anishinabe culture, traditions and role as grandparent as adults. They are now sharing the Anishinabe way of life with their grandchildren and teaching them how to lead a healthy lifestyle and that "alcohol is not good."

Changes in grandparenting style are reflective of the lifestyle and technological changes that have taken place in the last five decades. Respondents' activities with grandparents were interactive and focused on learning Anishinabe cultural traditions and skills for living off the land. As one respondent put it,

> ...in my early days there was no television, there was no radio, no telephone, none of these so story telling was quite popular, and we learned many stories from the grandparents, the parents and other elderly people. There was a lot of visits...a lot of it was communication. The education at that time that was important to them (grandparents) was for me to be, learn how to be a good trapper, how to be good fisherman, how to be a good harvester with natural resources...and the academics as we know them now was not really that priority for them.

Today, respondent's activities with grandchildren have changed significantly. Some activities involve promoting the culture by teaching grandchildren "how to have a good life" and helping in their education by reading and writing together. By far, the types of activities they are doing involve spending time together, but the activities are influenced

by an urban lifestyle and are diminished in their connection to the land. Some activities mentioned are as follows: going to shopping malls, watching television, going to movies, eating at restaurants, bike riding, going on picnics in the park, picking fruit, and going on boat and all-terrain vehicle rides.

How Diabetes Affects Relationships With Grandchildren

Respondents reported a number of physical and emotional symptoms that affected the ways in which they interacted with grandchildren. Almost all of the respondents said that as a result of their diabetes, they tire easily and set limits on the type of activities they do with grandchildren. One grandmother said that she experiences weakness in her arms and legs and she is "afraid to carry grandchildren." She also said that if she baby-sits, another capable person has to be with her in case the grandchildren need physical care. Some respondents indicated that they are not as active since they were diagnosed with diabetes and that it prevents them from going out as much. Several respondents also said that the diabetes gets in the way of playing with grandchildren. Respondents expressed frustration and anger at themselves because they want to do things with grandchildren but feel constrained by their lack of energy.

There were many emotional symptoms linked to the diabetes too. Mood swings were a predominant concern for respondents. Several respondents said that their diabetes made them feel irritable to the point where they do not like to be around the grandchildren. One grandmother said that "I don't want to interact with them when I'm not feeling good." Several respondents said that noise bothered them and made them feel irritable and cranky. Some respondents said that "sometimes I feel like I need to be alone."

Despite their symptoms, the respondents felt compelled to strive for a better future for their children and grandchildren. Having diabetes has made them think about their mortality, and it had given many of the respondents incentive to live better so they can live a long life and be there to watch their grandchildren grow up. Many respondents said, "I don't want them to get diabetes" so "I tell my children to watch what the grandchildren eat" and to encourage them to exercise. Respondents were also teaching their children and grandchildren about diabetes and "about being careful with sugar." Respondents are trying to control what their grandchildren eat, and when they are with them they try to feed them "proper food" that contains less fat and artificial sugar.

Living with Grandchildren

For the three respondents living with adult children and grandchildren, their roles were increased as they worked to fill the parts of both parent and grandparent. Their household responsibilities increased in addition to meeting the social and recreational needs of the grandchildren. These respondents were also working full and part time, and for them getting enough rest posed a challenge. The respondents spoke positively about the benefits they received by living with their grandchildren. For one respondent, live-in grandchildren were company for her and they filled her emotional needs. Living with grandchildren kept her mind clear and alert and helped her to feel young. This respondent also felt that living with grandchildren gave her the opportunity to teach them about "the emotional stuff" that she did not know how to do with her own children. She saw this as an opportunity "to do something different."

Role Satisfaction

When the respondents were asked if they were able to be the grandparents that they wanted to be, eight answered "yes" to the question. A couple of respondents were satisfied that they were able to provide social, emotional and financial support to their children and grandchildren. The respondents living with their grandchildren also felt content that they were contributing positively to their grandchildren's development in ways that they could not or did not do with their own children. Several respondents said that they would like to interact more with their grandchildren but in one case family conflict prevented this from happening and in another case the respondent wanted to see the grandchildren more than the parents would allow. Several respondents indicated that they would like more contact with their grandchildren; however, this was not possible due to their geographical distance.

What Respondents Would Change About Being a Grandparent

The most common response to what the respondents would change about being a grandparent was, "I wish I never had diabetes." One respondent said that he would not change a thing. Another respondent said that he would like to be a "great" grandparent while someone else said, "I caution my sons not to say make the same mistakes their dad did." Several respondents said that they wished that they lived closer to their grandchildren so they could have more contact with them while another said that if she were well she would like to take care of all her grandchildren. Another respondent wanted to "quit being grouchy" and another wished that she could do more physical activities with her grandchildren. One more comment was "I should have had more input into them attending more church."

How Grandchildren Are Perceived to React to Their Grandparents' Diabetes

From the responses given by respondents, it seems as though they are having an impact teaching their grandchildren about diabetes. Respondents said that they talk to their grandchildren about diabetes, foods, and the importance of being active. One respondent said "they ask a lot of questions," and "they ask me a lot about my...insulin." Other respondents spoke about discussions they had with grandchildren about "drinks, candy and stuff like that" and how grandchildren "make comments about food." Most of the respondent's grandchildren know about diabetes and they know that sugar is harmful to the body. One respondent said her grandchild "knows about sugar, that too much sugar for me is no good." This grandchild is watchful of the respondent's food intake and says "That's too much sugar nanny" or "you're using too much salt." The respondent's other grandchildren say " 'drink water nanny, that will get rid of your diabetes.' So water is very important to me."

Several respondents relayed stories of how their grandchildren try to help them care for their diabetes. A couple of respondents said that their grandchildren like to pretend to be nurses or doctors so they can "test my blood and they write it down for me." Two respondents said that their grandchildren are too young to discuss diabetes, and one respondent said that he would rather not "bring it out into the forefront because then it affects your family."

Health - Discussing Type 2 Diabetes and Diet

Respondents who grew up in rural and reserve communities tended to eat a diet comprised of both traditional (unprocessed) and foods bought in stores. The traditional foods consisted of fish, wild berries, moose, deer, and waterfowl. Many respondents

recalled helping their grandparents tend their gardens and eating a variety of vegetables. Respondents also recalled helping their parents and grandparents preserve foods by canning them. One respondent said, "In them days there was no refrigeration, no freezers. You had to learn how to preserve the foods that could be used last without refrigerating."

Co-Morbidity

Co-morbidity issues also affected a number of respondents. Three respondents had serious back problems. One of the three respondents had congestive heart failure, and a second respondent also had a heart attack and surgery on his back. The third respondent with back problems said that she had leg pain and could not stand or walk for more than two hours. A fourth respondent could not walk very well because of a bunion on the foot. A fifth respondent was recovering from a hysterectomy at the time of the interview, and a sixth respondent had arthritis. Respondents who had co-morbidity problems felt that their health issues prevented or limited them from interacting with their grandchildren in ways that they wanted.

Issues That Interfere With Being an Active Grandparent

There were a number of issues that interfered with the respondent's ability to remain active as a grandparent. First, was the diabetes itself and some of its physical effects. Some respondents felt they had physical limitations like tiredness, numbness in the legs, and loss of arm and leg strength. Several respondents had other physical health problems as well as type 2 diabetes, as mentioned above. Second, respondents attributed employment issues to limiting activity. A number of respondents had demanding jobs and poor eating habits that lowered their energy levels. A couple of respondents stated

that they frequently worked long hours, would forget to eat or eat the wrong foods. Third, one male respondent who likes to 'rough house' with his grandsons, said that he is very cautious about how he approaches his granddaughters and that he is not as active with them. He said "...a lot of times I can't do very much for my, ahh, my granddaughters because I respect them too much...." Fourth, one respondent found that by having to move to the city to access dialysis treatment for his wife interfered with and limited their abilities to remain physically active and connected to their family on the reserve.

Emotional Feelings Associated with Diabetes

Over half of the respondents expressed having negative feelings associated with their diabetes condition. Several respondents talked about having mood swings. One respondent in particular talked about a number of different feelings he had with his mood swings. He said,

> ... sometimes I get cranky, I don't want to, but I get cranky. And I think I get frustrated because I want to do things that I [pause] with the kids and I can't and I get so...I get so mad at myself cause I get tired, I get uhh, exhausted, and I can't...I can't do things that I want to do, and I get frustrated with my body and I just really...I don't know who I get mad at but it seems to be the people around me.

This respondent also felt frustrated because he wanted to do many things but could not, and he did not "like to sit around."

Another respondent said... "sometimes I feel umm, I need to be alone...I'm kindda grumpy a little bit and uh, the noise kind of bugs me..." This respondent also mentioned

that she could feel "that sickness" that comes over her from time to time. She also said that because diabetes symptoms are unnoticeable "...you don't look sick but I am sick, and I feel sick in the body." She said that it is difficult to convey to family and others how she really feels inside. She said that she feels "stuck" but she was able to tell her doctor that "I wanna be pampered too, I want people to care for me and do things for me."

Another respondent expressed similar feelings. She said... "sometimes you know when you're diabetic and you're tired...everything gets on your nerves. I try to explain that to my son sometimes...he really can't understand. I don't think he believes I'm sick."

Another respondent who lived with grandchildren stated other types of feelings.

> I guess in another way that what I find more of a negative thing I think for me is you know spending time with them. Sometimes I get irritable...but then that's just a part of you know my, how the diabetes is affecting how I feel and I don't... I feel guilty you know when if I'm in a bad mood and they're all happy and sometimes I don't like to be around them as much as I used to, ah, before I became diabetic and of course being older too ah, and having the diabetes, it kind of affects my relationship with them.

Managing Diabetes

Some respondents said that they manage their diabetes by involving the whole family. The majority are trying to change their own eating habits as well as those of their

children and grandchildren by encouraging healthy meal choices and snacks. Avoiding fast food restaurants is a decision that some are making to change eating habits and to keep their weight down. Some are making a conscious effort to drink more water and to eat at certain times.

Most of the respondents believe that regular exercise will help to stabilize their diabetes condition. The exercise most respondents did was walking. One respondent said that he is trying to incorporate more walking into his lifestyle by parking in places away from his destination and taking stairs instead of an elevator. Other activities that were mentioned were swimming, biking, and running on a treadmill. A couple of respondents said that they remain active in sports. Almost all of the respondents were aware that they needed to "live with less stress" and get more rest.

Another way that they manage their diabetes is by learning about diabetes. One respondent said that after he was diagnosed with type 2 diabetes he did not take it seriously but that has changed. He stated... "now that I do and I see pictures of different things that could happen to you, it gave me a wake up call of losing toes and limbs and stuff like that. It's really scary." A few respondents also checked their blood pressure regularly and several respondents tested their blood sugar twice a day.

Another self-management technique that a few respondents discussed was to accept the diabetes. One respondent said "it's something you have to accept from the start, which I didn't" and two others said "Denial is not the answer. People have to learn to live with it, and learn to be friends with it."

Self-Care

For one respondent living in a clean environment was vital to self-care. This person grew up knowing how important it is to one's health to bathe regularly, wear clean clothes and to sleep in a clean place. As a diabetic, this respondent said that these are good habits to have in order to stay healthy. "Eating proper food" was another factor in maintaining good health. Several respondents discussed how they are making efforts to cut down on fast foods, eat smaller portions, and to consume foods and beverages with less sugar and salt. One respondent said,

> It's a very rare occasion that I'll have a drink that is not diet Coke or diet Pepsi or diet 7 Up or something, very rare. So I've switched that. Ah, I used to go to...not all the fast foods places but I would go to the McDonald's, go to the Wendy's, go the the A&W. For me now, it's about once a month if I do something like that. I've changed that you know.

Most respondents also reported that keeping active and playing sports is important to maintaining good health. Most of them try to walk but some also swim, ride bicycles or play sports like golf in order to stay active. One respondent who cut down on fast foods and started walking more noticed that he lost weight, and his wife reported that his "color is better" and his "hair looks better." Two other respondents who do a lot of physical work said they feel fit and they believe the work helps keep their diabetes in control.

A couple of respondents disclosed that they do not drink alcohol or smoke because they are aware of the consequences these substances have on their health. Most respondents were aware of the importance of getting enough rest. A couple of

respondents who experienced loss of physical strength and numbness in limbs talked about how they had to give up doing certain activities that caused them too much stress. One respondent also shared that after a hectic day at work he plays video games at home to relax.

Several respondents mentioned that it is important to be on the proper medication and to take the medication as prescribed. Seven of the respondents stated that they take pills to regulate their blood sugar levels and one reported being on both pills and insulin. Two respondents did not disclose whether they take any medication. Respondents who had co-morbidity issues indicated that they had regular medical check ups. Over half of the respondents also checked their blood sugar levels on a daily basis. Only two respondents reported that they have not changed eating habits. One respondent said she eats everything and does not take her pills everyday because she says, "I don't believe I'm sick." The other respondent stated that she could not maintain a diabetic diet on a consistent basis because of the cost of the food.

Traditional Healing Practices

Only one respondent reported using traditional cultural healing methods along with Western medicine in order to control the diabetes. This respondent was familiar with different traditional medicines that are used to treat high blood pressure and heart disease. This respondent also drank a lot of water, which is a sacred gift to the Anishinabe people because it cleanses and heals the body. The respondent said that she is "very active in sweat lodges" and attends them at least four times a month. In addition to this she said "I Sun Dance each year. That's four days of Sun Dancing and that's without food and water. What I just simply do is I stay off of Metformin at that time cause I'm not putting

anything in my body, and I test my sugar all the time, and it goes normal, perfectly normal for those four days."

Education – A Message for Future Generations

There was an overwhelming desire by the majority of respondents to seek information and learn about diabetes and use the information to improve their health status and that of their children and grandchildren. When some of the respondents were diagnosed with diabetes they were given general information about diabetes from doctors and nurses. Several respondents were given pamphlets to take home and read. One respondent was advised to see a dietitian at a local hospital where he attended several meetings about how to make diet and lifestyles changes. Other respondents sought additional information from various sources. For example, a couple of respondents read books on diabetes and attended workshops and conferences. Another respondent used the Internet to retrieve information on diabetes. All of the respondents felt it was important for them to pass this information on to their children and grandchildren to prevent them from getting diabetes.

Respondent Perceptions of the Causes of Diabetes

Four respondents said that they believe that the high rate of diabetes among Aboriginal people is largely attributed to changing lifestyles. One of these respondents said,

> We were food gatherers. We lived sort of a nomadic existence during the summer months. We moved around but we did have permanent places to stay as well in the winters. But, we had a lifestyle that was quite different from

> what we've had to live after the White man got here. A lot of it had to do with our diet I think...Different foods were brought in from different parts of the world, introduced to a people whose main diet was wild meat and buffalo.

These respondents agreed that what we eat now, such as fast foods and junk food, has contributed to the diabetes epidemic in the Aboriginal population. One respondent said "A lot of this problem with diabetes is something that we brought upon ourselves...in many ways we abused our system extremely by our intake of junk food that we ate."

This same respondent recalled, as a child, how busy he was working off the land with his parents and grandparents and performing traditional job skills to survive from the land. He said,

> In them days the children were at an age where you could help something, say for instance in fishing. If you could help anything in fishing at a very early age that's where you work instead of school... like I remember my mom putting me to work when she would be processing hides...I did all the hide work...in my younger days. That's where the children were used and of course and I'm not saying they were ignorant but they just didn't have the foresight that the change would actually happen in this short period of time which did happen.

He described how in the late 1950s his reserve community was economically and socially devastated by a flood. The response by the government in the day was to build "a water controlled structure" which further affected the lake levels and destroyed the

fishing and trapping economies and natural breeding grounds for wild fowl and small game such as muskrats. He stated "...it completely disrupted our way of living... and in ...1954-55, that winter was the first time we hear of welfare being provided to people." A couple of respondents also believe that the rapid lifestyle changes and the lack of Aboriginal peoples' participation in today's economy has left them in a dependent state "sitting around and not doing anything" with inadequate "coping skills."
Another respondent said "It's the lifestyle, definitely the lifestyle, what we eat, fast foods is a killer for people, umm...not doing anything is also a killer, sitting around and not doing anything that's a killer."

One respondent also believes that there are many Aboriginal people who have diabetes and do not know it because "they're not really sick, they're not really feeling the effects of diabetes, 'cause I don't. Like I didn't have the typical symptoms of diabetes like thirst and stuff they talk about, I didn't have that. I felt okay. And one day I went for a check up and my sugar was too high." She added that when a person is diagnosed with diabetes and does not feel the symptoms there might be a tendency to deny the diabetes.

Recommendations for Diabetes Management

The majority of respondents felt that education is key for diabetes management. They are aware that there is no cure for diabetes. The sooner a person learns to accept his or her condition and makes the necessary lifestyle changes, the more likely health related outcomes will be positive. They said that the individual has to take responsibility for it and then look after him/herself. They said that worrying about it does not help the person so "You make the best of your life." A couple of respondents said that "people have to learn to live with it and accept it...and learn to be friends with it."

Another respondent believes that having a positive attitude and outlook can increase a person's coping abilities. He said, " You learn to live with things and the best thing you can do is cope. You know you can make the best of a very bad situation and still come through it...." This respondent also said,

> ...I never think of myself as having numbered days. As far as I'm concerned...I'm going to be as happy as everybody else in 20 years whether I'm living or not. I do not look at my life one day at a time. I have long range plans... when you start living your life one day at a time... you're just trying to beat the clock.

One other respondent felt that it is important to educate children about diabetes at an early age. She said that diabetes education is vital to an early diagnosis, and that diabetes education should be incorporated into the school curriculum in the early grades.

Summary

Some important advice from respondents was to "be serious about this disease...and look after yourself." If you can accept it from the start and look after yourself "you could live longer..." Another important piece of advice was to face it, do not deny it and do not give up. As one respondent put it "you control it... don't let it control you...you're the boss."

The results of this study demonstrate that respondents believe that their diabetes is a result of living through five decades or more of rapid social, cultural and societal changes. They felt that the major factors that have contributed to their diabetes condition were dietary changes, lifestyle changes, lack of participation in the economy, and a lack of coping skills.

Over half of the respondents recalled having childhood experiences with grandparents that enriched their lives as individuals and later as parents and grandparents. All of the respondents could recall some cultural teachings, legends, religious customs and practices, work experiences and fun things that they did with their grandparents. Several respondents indicated that they are practicing many of the life lessons they received from their grandparents and are passing these on to their own grandchildren.

Evidence suggests that most of the respondents were informed about diabetes and were aware of what they must do in order to take care of themselves. It was apparent that the participants were making efforts to learn about diabetes and reported making lifestyle changes based on what they learned. Further discussion of the results is found in the following chapter.

CHAPTER 6: DISCUSSION

The purpose of this study was to gain insight into how Anishinabe grandparents who are diagnosed with type 2 diabetes view their roles and responsibilities in child rearing and how they interact with their grandchildren. The focus of the research was also on the social impact that the grandparents' diabetes is having on their relationships with their grandchildren. The first research objective was to identify traditional roles of grandparents in the extended family system as recalled by the respondents. The literature showed the traditional Anishinabe lifestyle and extended family organization. Anishinabe people were hunters and gatherers and they lived a seasonal migratory lifestyle. Anishinabe family systems were organized into extended family and clan systems. The extended family system had a social structure that guided the family units spiritually, socially, economically and politically. The extended family and clan system provided a philosophy of interdependence and provided the boundaries of relationship and responsibilities and expectations to its members. Extended family members' roles were clearly defined (Blanchard, 1977; Peers, 1987; Ray, 1998).

The traditional role of Anishinabe grandparents was very important because their task was to transmit the culture and traditional knowledge to the next generation. They were the advisors, teachers and mentors of both adults and children. The grandparents modeled and transmitted the Anishinabe way of life through an oral tradition (story telling) and by role modeling (Blanchard, 1977; Hart, 1995). The traditional Anishinabe lifestyle that was in existence for thousands of years changed dramatically after European contact.

The colonization of Canada by Europeans transformed the Anishinabe peoples' way of life. The literature documents how European domination and control over land and natural resources and the introduction of foreign diseases and foods contributed to the declining health of the Anishinabe people. The fur trade changed many aspects of the traditional Anishinabe lifestyle such as marriage, kinship patterns, roles, values and traditional customs and practices. Grandparent roles diminished during the fur trade exchange period as younger generations participated in it (Ray, 1998). The colonial government's Indian policies further advanced their political plans to marginalize and assimilate Aboriginal people including the Anishinabe (Friesen, 1984).

One Indian policy that directly affected four respondents when they were young was the residential school system. The four respondents were all negatively affected by this school experience. The respondents remembered the loneliness of being separated from their families for ten months of the year. They recalled how the residential school system caused the loss of family connections, culture, customs and traditions. As indicated in the literature, government and church officials eliminated all contact with grandparents at the schools because they recognized the strong cultural influence that grandparents had on grandchildren (Ing, 1991). The loss of bonding to grandparents was more apparent to those who spent more time at the residential schools. Two respondents said that when they returned home on summer breaks there was never enough time to get re-acquainted with their grandparents and to learn from them. Therefore, in a very short period of time these respondents lost their language, knowledge of cultural traditions, traditional teachings, and practical life skills that their grandparents would have taught them to prepare them for their future. When the respondents completed school they stated that

they felt confused and unprepared for adulthood. The loss of traditional child rearing practices was felt even more strongly when the respondents started having families. Several of the respondents stated that they did not know how to parent, and they had difficulties nurturing and expressing love to their children. Evidence suggests that the respondents who were disconnected from family and community when they were children felt unprepared for family life and often resorted to unhealthy coping strategies (Grant, 1996).

Fortunately, over half of the respondents did have varying amounts of contact with their grandparents. Three respondents recalled having strong attachment and bonding to their grandparents, while three had minimal contact and few recollections of their grandparents. The respondents who spent time with their grandparents recalled learning Anishinabe cultural teachings and traditions from them. The respondents also recalled doing activities with them that are associated with a traditional lifestyle such as hunting, fishing, trapping, tanning hides, berry picking, gathering roots and herbs, going to pow wows, story-telling, and learning how to make moccasins.

The federal and provincial governments and the churches of Canada declared residential schools a success as they eroded the social, cultural and environmental systems of the Anishinabe people (Grant, 1996). From the time the respondents were born there have been enormous changes in these three areas. Although residential schools are no longer operating in Canada, Anishinabe people, families and communities are still confronting the aftereffects of the schools. Many families and communities are struggling to preserve social cohesion and restore cultural identity and traditions that were denied them through the government's assimilation policies.

One respondent said that his grandparents tried to teach him his future role when he was a young boy, but it was difficult because his community experienced flooding after a dam was built causing severe ecological damage to the land and wild life. He said that the dam disrupted their traditional way of life, causing the people a lot of grief and hurt. He stated that the people's health declined, as they became increasingly dependent on Indian Affairs for food rations and welfare. The literature review and the results of this study indicate that the prevalence of type 2 diabetes among the Anishinabe is believed to be linked to the vast socio-cultural and environmental changes that they have experienced. The main factors believed to be contributing to type 2 diabetes among Aboriginal people are cultural disruption, a sedentary lifestyle, a change in diet, unemployment, poverty, stress, cultural barriers, and dependency on external institutions (Chaddock, 1998; Keyayosh, 1993).

The second objective of the study was to get the perspectives of the respondents on their roles and responsibilities in child rearing and to determine if they think they are performing the grandparent role differently from the ways in which they were grandparented. The respondents' roles and responsibilities in child rearing have changed over the past 60 years; however, half the respondents are still continuing some of the traditional child-rearing practices that they learned from their parents and grandparents. These respondents were fortunate to be able to spend a lot of time with their grandparents and to receive cultural teachings from them. The respondents recalled their grandparents as positive role models who taught them their roles, how to do tasks and prepare them for adulthood. Some of the ways in which grandparents taught cultural teachings were through play, story telling and participating in cultural events and activities together.

Respondents indicated that they are using similar teaching methods in their grandparenting roles despite the social, cultural and environmental changes that have occurred.

The respondents are also doing a number of things differently from the ways in which they were grandparented as a result of residential school policies that were used to assimilate them. One finding of this study that is contributing to the changes in Anishinabe child-rearing practices is the influence that residential schools have had on the respondents. According to Grant (1996) and Ing (1991), the forced separation of children from their families was intended to break the familial and cultural ties of the children and to assimilate them into the dominant culture. In order to accomplish this Anishinabe children were removed from their families at a young age and placed in residential schools often at great distances from their home. By keeping them apart, state officials hoped to erode the children's Anishinabe identity, language, customs and practices and force them to adopt a Euro-Canadian identity and culture. The Canadian government and churches proclaimed residential schools a success.

The respondents who attended residential schools recalled that, in their absence from home, they lost their bonds with family and traditional knowledge and practices. The results of this study are in agreement with literature suggesting that once the children left the residential schools they were confused and unprepared to live in the Aboriginal community and in mainstream society (Grant, 1996). With few supports in place to help them they had a difficult time fulfilling their parental roles and fitting into their environment. This is clearly evident by the vast number of Anishinabe children who were removed from their parental homes and placed in foster care and adopted into non-

Aboriginal homes (Hudson & McKenzie, 1981). Although most of the respondents endured cultural disorientation and family dysfunction during their childhood years, it is not known if they spent any time in the child welfare system.

A second finding that is affecting how respondents are performing their role differently from the ways in which they were grandparented is employment. Respondents who were employed stated that they experienced additional stress and fatigue from their diabetes. As a result, respondents said that they did not go out as much as they did before they had diabetes. They set limits on the amount of time spent with grandchildren and the types of physical activities they did with them. They tended to do activities that did not require a lot of time or energy such as talking, going on walks, picnics, watching movies and reading together. Four of the respondents who worked tended to use the Anishinabe oral tradition more than role modeling to teach their grandchildren cultural knowledge and values such as respect. The respondents indicated that they talked to their grandchildren about diabetes and diabetes prevention and are trying to encourage their children and grandchildren to eat healthy and to exercise. Only one respondent who worked participated in traditional cultural activities with the grandchildren.

A third finding indicated that residency pattern of respondents and grandchildren also affected the ways in which grandparents performed their roles in child rearing. This study found three respondents living with grandchildren while seven respondents lived with their spouse and/or other family members. The respondents living with grandchildren stated that they experienced a lot of fatigue due to their increased roles and domestic chores. They also felt physically and emotionally drained by the extra work

and found it difficult to get adequate rest. They also said that the diabetes made them cranky and irritable and noise bothered them. The respondents said that they did not like to be around the grandchildren when they were not feeling well.

Less than half of the total number of grandchildren for the respondent group lives in Winnipeg and the remainder lives in rural Manitoba, mostly on reserves. Five grandchildren lived in two other Canadian provinces and two of the respondents only saw these grandchildren once a year. The geographical distances between the respondents and their grandchildren made it difficult to influence grandchildren in the same way that those respondents' grandparents did. Five of the respondents saw their grandchildren one to four times a month.

The results of the research indicated that respondents are no longer doing activities with grandchildren that teach them about their connection to the land and nature. Half of the respondents who were not close to their grandparents and did not receive cultural teachings said that they are grandparenting completely differently than they believe their grandparents did. Most of the activities that grandparents are doing with grandchildren are not Anishinabe cultural activities. They are reflective of urban lifestyles. Some of the respondents started learning about their culture as adults but they are not passing it on to their grandchildren as their great-grandparents may have. It is speculated that residential schools may have affected the respondents' grandparents as well, which was instrumental in stopping the transmission of Anishinabe culture.

The third objective was to examine the perceptions of Anishinabe grandparents with type 2 diabetes and to analyze its impact on the grandparents' abilities to perform their traditional child rearing roles. There were only two respondents who were diagnosed

with type 2 diabetes less than five years ago. Eight respondents had diabetes for 11 to 24 years. Nine respondents had close family members with diabetes and all nine had a family member who died from diabetes complications. Only one respondent was the first in her extended family system to have type 2 diabetes. All but one respondent were taking their diabetes condition seriously by taking prescribed medications and trying to make dietary and lifestyle changes. Most of the respondents discussed how difficult it was to initially accept their diabetes. They talked about going through a series of emotional phases similar to a grieving process before they accepted their condition. Six of the respondents also had co-morbidity issues that created further limitations on the interactions between them and their grandchildren.

Several respondents had concerns about their mortality. They talked about relatives who have had diabetes complications such as limb amputation, heart disease, renal failure and stroke. The respondents expressed their fears that one of these consequences might happen to them. A couple of respondents stated that it was a feeling of fear that motivated them to try and control their diabetes. Other respondents expressed a desire to live long enough to watch their grandchildren grow up, graduate from school, get married and have families of their own.

Three of the respondents demonstrated serious debilitating effects from their diabetes and co-morbidity health issues. They indicated that their health status greatly restricted their ability to perform general child-care duties. One respondent and his wife had to leave their reserve and move to Winnipeg for her to gain access to dialysis treatment. This placed an additional strain on the couple, as they could no longer perform any child

rearing duties that they were accustomed to as most of their family was situated on the reserve.

Over half of the respondents also mentioned that their diabetes condition made them feel physically and emotionally drained. They felt that the diabetes was creating limitations on the amount of time they could spend with grandchildren and the types of activities in which they could engage. Respondents indicated many emotional feelings such as anger, frustration and irritability when they were in the company of grandchildren and did not feel well. Most of the respondents felt that they could not carry out their grandparent role to their expectations, even though 80% expressed role satisfaction. The results of the research indicates that over half of the Anishinabe grandparents interviewed felt that they were not able to perform traditional child rearing roles due to living in different cities, diabetes, and other health conditions.

Since diabetes is a relatively new disease in the Anishinabe population that came to the attention of health providers in the 1970s, there is very little written on the social impact diabetes is having on families on account of there being too many changing variables that can not be sorted. The results of this study provided a glimpse of how Anishinabe grandparents with type 2 diabetes are interacting with grandchildren and what their concerns are regarding the health and well being of their children and grandchildren.

The results demonstrate that the Anishinabe culture and family are evolving and adapting to the present social and environmental conditions and the cultural elements are not keeping up with the changes. It was speculated that their views and experiences would be diverse because of the impacts that colonization and urbanization have had on

the Anishinabe family system. This is evident by the way respondents viewed how they perform the grandparent role compared to how they were grandparented.

The literature provided some information relating to the third objective examining the perceptions of type 2 diabetes affecting Anishinabe grandparents. The results demonstrated the impact on the grandparent's ability to perform their traditional child rearing roles. This has serious implications for Aboriginal communities where traditional child rearing customs are still practiced by the grandparents. It also has significant implications for First Nation's Child Welfare agencies that often rely on the grandparent population as primary care givers for children in the community.

Ecological Theory

Ecological theory is rooted in evolutionary theory of adaptation that examines human development as a complex system of relationships affected by multiple levels of environmental systems (White & Klein, 2002). Bronfenbrenner's ecological concepts of human development views different levels of the environment as a series of nested structures. This theoretical model was effective in examining how the respondents in this study interacted at the biological context, microsystem, mesosystem, exosystem and macrosystem levels within their family systems and other external systems (White & Klein, 2002).

At the biological level, none of the respondents were born with diabetes. All of the respondents grew up with their family of origin or extended family. Four respondents experienced family separation and disruption during childhood as a result of attending residential schools. Respondents did not report any physical health problems in their childhood or adolescence. The respondents all developed type 2 diabetes as adults.

At the microsystem and mesosystem levels where an individual lives and family interaction and connections among microsystems take place, it was noted that only one of the respondents was born and raised in Winnipeg and a second respondent moved to Winnipeg when she was a young girl. Seven respondents were raised in reserve communities and one was raised in a farming district. As mentioned, four of the respondents who were raised in rural Manitoba attended residential schools as children. For them, school officials and fellow students were their only social connections while in the institution. It was evident by their stories that the longer they remained in this school setting the greater the negative impacts were on their overall development and connections with family and other systems.

At present, three respondents live with grandchildren. In these situations, the respondents are more active in their communities with schools, recreational facilities and other community resources. In one case a respondent and his spouse had to leave their reserve and move to Winnipeg to gain access to dialysis treatment. This move, although necessary, placed additional burdens on the couple to find an apartment, adapt to the new environment, establish new routines and familiarize themselves with local resources.

It was evident from the results that the respondents who had more exosystem connections to family, friends, neighbors, workplaces and community health services demonstrated more secure lifestyles and positive outcomes with their diabetes conditions than those who had experienced more disruptions in these areas. The respondents who had less life changing disruptions in their lives appeared to accept and take responsibility of their diabetes sooner and to make the required lifestyle changes. They demonstrated more positive interaction and connection with other ecological systems and appeared to

have more support systems in place. They viewed their diabetes as something that they had to learn to accept and control and they were generally more optimistic about their future.

In comparison, it appeared that respondents who had fewer social supports and financial resources in place expressed less satisfaction in their personal lives and appeared to have more problems coping with daily living. When they spoke about their diabetes they expressed a lot of emotional distress. They appeared to have more difficulty communicating their needs to their families and external institutions. They did not take adequate care of themselves and they had more co-morbidity issues. They discussed their concerns of diabetes consequences and spoke about their future with uncertainty, as they were unsure of who would take care of them. One respondent stated that she did not want to be placed in a health care facility, as she would be more comfortable living with one of her adult children.

At the macro level several respondents discussed their knowledge of the role of traditional medicine people and healers and Anishinabe health practices in regards to healing diabetes and other illnesses. Two respondents had a grandparent who was a medicine person, and one respondent has two siblings who are healers. Although some respondents were familiar with cultural healing methods, there was only one respondent who was combining traditional healing methods and Western medicine as part of their medical treatment. A second respondent was using traditional medicine for spiritual reasons. Some respondents said that they did not use traditional medicine because they either adopted a new religion, feared traditional medicine or they did not have cultural knowledge of it.

The literature indicates that the breakdown of cultural determinants related to health-related behaviors in addition to experiencing "negative spillover" between two microsystems, increases the risk for negative health outcomes (Gochman, 1988; Grzywacz & Fuqua, 2000). Furthermore, Young, et al., (2000) say that supportive environments must be in place to assist individuals to make behavioral changes. For those respondents who experience daily living problems with type 2 diabetes and do not have positive support systems in place, it is speculated that their diabetes will continue to threaten their overall well being and they may experience a further decline in their health status.

Medicine Wheel Theory

The medicine wheel theory was an appropriate framework to use to provide a cultural context of the Anishinabe worldview and traditions. Similar to ecological theory, the medicine wheel was used to interpret how people fit and are interconnected with each other, the environment and universe. It is particularly useful for examining how people are adapting in their environment. It is a holistic theory of human development that emphasizes balance in the spiritual, emotional, physical and mental parts of the individual. It integrates spirituality as a core component to understanding phenomenon of any kind (Cajete, 1999). The medicine wheel teaches people that in order to grow in knowledge and wisdom and to achieve balance, one must walk in all four directions to get a full understanding of the different gifts, medicines, values and responsibilities of living a spiritual life. Anishinabe people believe that an individual can achieve balance by practicing the oral tradition, traditional customs, laws and ceremonies that teach the

individual how to live in health. These teachings include spiritual directives on how to live a full and balanced life (Cianci & Nadon, 1987).

In Anishinabe culture one's health is viewed as a gift from the creator that is to be respected and maintained to the best of one's ability. Anishinabe people believe that when one is ill it is a result of being off balance in one or more of the four mentioned domains that make up the whole person. The respondents of the study viewed their diabetes in part as a physical imbalance that is caused by what they put into their body and the lack of physical activity.

The results of the study demonstrate that very few respondents are using traditional Anishinabe religious practices and medicine to heal themselves. Only one respondent practiced traditional Anishinabe healing methods several times a month to regulate the diabetes and spoke about the concept of maintaining balance in her life. A second respondent incorporated prayer and smudging with sweet grass on a daily basis. A third respondent who was familiar with traditional medicine said that she used traditional medicine on her grandchildren when they were teething however she did not report using it herself. Several other respondents recalled attending ceremonies and learning cultural teachings and traditional medicine from their grandparents when they were young but they did not say whether they practiced them now. Eight respondents disclosed that they used Western medicine to treat their diabetes.

It is speculated that part of the reason for the lack of use of Anishinabe medicine is that traditional healers, teachings, ceremonial grounds and medicines are not as accessible to them. There are only a small number of formal cultural/spiritual support systems available in the city where these respondents currently live. It was also evident

that some of the respondents have lost traditional knowledge and customs through the assimilation process. One must also consider the fact that Anishinabe religion and spirituality have been suppressed and undermined by colonial forces to the level where people are sometimes afraid to discuss them. It could also be that perhaps people have lost too much knowledge of traditional religion for it to have relevance in their lives.

Several respondents said that they believe they have diabetes because of the fast foods and junk food they have eaten which has caused a physical imbalance in them. One respondent referred to diabetes as a 'White man's disease' that has been forced upon the Anishinabe people through colonialism. Many respondents also believe that diabetes is rampant in the Aboriginal population because of the socio-cultural upheaval and the dispossession of the land and natural resources.

It is also important to note the occurrence of denial (Boss, 2002). One respondent discussed his feeling of shock and fear of possibly having to take needles when he was diagnosed with diabetes. This respondent also stated that even though he knew he had diabetes, he ignored it for a year and continued to live life as he normally did. Three other respondents also stated that they also lived in denial of their diabetes for some time following their diagnosis and did not do anything about it until their symptoms could no longer be ignored.

All of the respondents were aware that diabetes is incurable. Even though most of the respondents have lost close relatives to diabetes, none of them expressed any feelings of diabetes being a death sentence. Some of them did discuss their fears of diabetes complications and stated that they were challenged by their fears to make lifestyles changes such as quitting smoking and drinking alcohol. Three respondents indicated that

they know that if they accept the diabetes and take care of themselves properly they can increase their chances of living longer and being there for their grandchildren.

Over half of the respondents were knowledgeable about diabetes and most were making efforts to pass this information on to their children and grandchildren in order to prevent them from getting it. There were two respondents who believed that genetic transference of diabetes is inevitable and they were making positive lifestyle changes and teaching diabetes prevention to their children and grandchildren to delay its onset.

CHAPTER 7: CONCLUSION

This research showed insight into how Anishinabe grandparents who have been diagnosed with type 2 diabetes view their roles and responsibilities in child rearing and how they interact with their grandchildren. In order to examine the social impact that diabetes is having on the grandparent/grandchild relationship, there were three objectives designed to attain first hand knowledge and perspectives from Anishinabe grandparents. The first objective was to identify traditional roles of Anishinabe grandparents in the extended family system as recalled by grandparent participants. The second objective was to get the perspectives of Anishinabe grandparents on their roles and responsibilities in child rearing and to determine if they think they are performing the grandparent's role differently from the ways in which they were grandparented. The third objective was to examine perceptions of type 2 diabetes affecting grandparents and to analyze its impact on the grandparents' abilities to perform their traditional child rearing roles.

In regard to the first objective, it is evident that the respondents could identify traditional roles that their grandparents performed. The traditional roles of grandparents involved the transmission of the Anishinabe culture, religion, history, language, social customs and values to younger generations through the oral tradition and role modeling. Many of the respondents recalled spending time with their grandparents and learning their traditional ways from them when they were children. They also did activities that were reflective of the traditional Anishinabe lifestyle sixty years ago. Some of the things they did together involved traditional harvesting activities such as fishing, hunting, trapping, tanning hides, berry and root picking and gardening. Other activities that many respondents remembered doing together are story telling, beading, making moccasins,

cooking, outdoor chores, learning about nature and going to ceremonies. Only one respondent recalled living with her grandparents for a short time when she was a young child. With the exception of one respondent who seldom saw his grandparents because they lived a long distance away, the rest of the respondents lived near their grandparents in separate residences. They did recall having a lot of contact with their grandparents especially on weekends.

On the other hand, results showed that the extended family system was undergoing social structural change when these respondents were children. Residential schools were major contributors to family disruptions and family disorganization and dysfunction. When respondents had to leave home to attend residential schools they lost familial bonds particularly their spiritual and cultural connections to grandparents. In addition, the natural environment also changed. One respondent recalled how environmental changes that took place in his community destroyed the natural ecology and disrupted the people's traditional lifestyles that resulted in creating a dependency on external institutions.

Half of the respondents recalled being influenced by their grandparent's traditional child rearing practices when they were growing up. The traditional practices involved grandparents teaching grandchildren about their culture and identity, people's relationship and responsibility to the land and to each other, family values, how to live a good life, religion, morality and spirituality. It was the responsibility of Anishinabe grandparents to teach grandchildren about their traditional ways of life. Although the traditional Anishinabe lifestyle and child rearing practices have been undermined and weakened from assimilation polices by external institutions in the last sixty years, three

respondents indicated that they are continuing to perform some of these practices in their relationships with grandchildren. The respondents indicated that they are teaching grandchildren through the oral tradition by spending time with them and telling them stories and passing on cultural beliefs and values. These respondents are also participating in traditional cultural activities and ceremonies that reinforce the traditional ways of life. Another two respondents were teaching grandchildren through the oral tradition but they seldom participated in cultural activities with them. The remaining five respondents did not practice traditional Anishinabe culture.

In regard to the second objective, there were three findings related to the perceptions of respondents who said that they were performing the grandparent role differently from their grandparents. The first finding was related to respondents attending residential schools. Four of the respondents had minimal to no contact with their grandparents when they were growing up because they had to leave home to attend residential schools. The respondents lost connections to grandparents and the cultural knowledge they would have received from them. These respondents indicated that they felt confused and unprepared for life when they left the schools. They had difficult forming positive relationships with others and had problems raising their children. They also said that they had problems coping with life and struggled with addictions.

The second finding that is associated with respondents performing their grandparenting roles differently is employment. Five respondents were working on a full time basis and one on a part time basis. Most of them indicated that they felt stress and fatigue from work and their diabetes condition. This limited the amount of time they

spent with grandchildren and the types of activities they did with them. Only one respondent who worked participated in cultural activities with the grandchildren.

The third finding is that residency patterns of the respondents and their children and grandchildren also affected the ways in which the respondents performed their child rearing roles. Two respondents lived with their adult children and grandchildren and one respondent had a grandchild living in his home. Seven respondents lived with their spouse or other family members. The respondents who lived with grandchildren stated that it placed extra responsibilities on them and as a result they often felt physically and emotionally drained. They did however find the experience emotionally gratifying.

The rest of the respondents who lived near grandchildren planned visits around their needs. Less than half of the respondents' grandchildren lived in Winnipeg, five lived out of province and the rest live in rural Manitoba communities. The distance between them in addition to working made it difficult for respondents to see their grandchildren very often and to play an influential role in their lives.

Half of the respondents stated that they are performing the grandparent role differently because they did not have the opportunity to learn child rearing roles and responsibilities from their parents and grandparents. This was evident by the activities that they do with grandchildren that were more reflective of an urban mainstream grandparent culture.

In regard to the third objective, there were many perceptions of type 2 diabetes affecting Anishinabe grandparents and their ability to perform traditional child rearing roles. Nine of the respondents had immediate family members with diabetes and all nine had family members who died from diabetes complications. All but one respondent was

taking their diabetes condition seriously. Several of the respondents said that when they were initially diagnosed with type 2 diabetes they lived in denial for over a year before they acknowledged it. Then they experienced a series of intense feelings that are often associated with a grieving process. It was clear that several of the respondents were at different levels of this cycle. Four of the respondents indicated that they have worked through all of these intense emotional feelings and have come to accept their diabetes. Two of the respondents stated that they "had to make friends with it" before reaching the final stage of acceptance. They strongly believe that they can now move forward in their lives and they can see a future for themselves.

Six of the respondents had co-morbidity issues that affected their perceptions of type 2 diabetes and their ability to perform their roles and responsibilities in child rearing. These respondents indicated that their multiple health conditions made them think about their mortality. They discussed their fears about diabetes complications as they have all witnessed this devastation first hand. This level of understanding of diabetes has made them realize that they have to take proper care of themselves by taking medication, changing their diet and remaining active so they can improve their quality of life and longevity.

Three of the respondents demonstrated serious debilitating effects from their diabetes and co-morbidity conditions. Their health status greatly restricted their ability to perform their roles as grandparents and any child care duties. All of the respondents reported that their diabetes physically and emotionally impeded their ability to perform their grandparent roles. They all felt limited in their interaction with grandchildren by factors such as time, energy level, the activity and how they were feeling emotionally. As a

result, most of the respondents said that they could not carry out their grandparent roles to their expectations.

Implications

Researchers speculate that the prevalence of type 2 diabetes and the high rates of premature deaths from diabetes complications will have significant implications for Anishinabe family and community organization. Research supports that aboriginal men are twice as likely to die from diabetes complications and aboriginal women are four times likely to die from the same circumstances (Human Resource Development Canada, 2000). Mortality rates from diabetes among Aboriginal people is double the national average in Canada (Bobet, 1997). This is of concern because Anishinabe grandparents have always played important roles in the family and the community as advisors, teachers and caregivers. Still today in all of the Anisninabe communities in southern Manitoba where diabetes rates are highest, Anishinabe grandparents have been a major resource to First Nation's Child Welfare Agencies in providing foster care to children. As a social worker I am aware of the countless services that grandparents provide for children and to other community programs. Since type 2 diabetes is taking its greatest toll on Anishinabe people over 40 years of age who live on reserve and in rural areas, it will have policy implications for First Nations Child and Family Service agencies regarding child placement protocols. The agencies may have to consider alternative placement options or continue to shift more of their practices and resources into prevention services for families. Focusing on the empowerment of parents will have long term implications for strengthening and maintaining family and cultural preservation.

Researchers of social ecology of health state that "health is an outcome of the quality of person-environment fit" (Grzywacz & Fuqua, 2000, p. 2). They examine the psychosocial environment and the cultural and individual determinants that influence health across the life span. They also state that "Certain individual or environmental conditions exert a disproportionate amount of influence on health and well being" (Grzywacz & Fuqua, 2000, p. 2). The results in the study indicated that the Anishinabe people's experiences of dispossession of land, forced assimilation, cultural disruption; rapid lifestyle change, dependency and poverty have all contributed to the high prevalence of diabetes, complications and mortality rates. The implications for this "preventable" human atrocity are widespread and will require extensive interventions at all of the ecological systems levels in order to develop supportive health strategies and treatment options that are accessible and culturally specific for Aboriginal peoples. A significant starting point would be for the scientific health community to acknowledge, respect and promote traditional Aboriginal healing practices and principles from traditional lifestyles. Many Aboriginal people have stopped using their healing practices for fear of retaliation from officials in authority over them. Spiritual and cultural revitalization are key to finding solutions. The results of this study indicated that when respondents had strong connections to their culture and their past, they demonstrated more stability in themselves and in all aspects of their lives. An important health strategy would be for health systems to advocate for improved living conditions of Aboriginal peoples by providing more opportunities for education and employment since they are directly and positively linked to health outcomes.

In this research respondents provided a wealth of knowledge of how type 2 diabetes is affecting their lives on a daily basis. The respondents provided understanding about quality of life issues such as the emotional and physical health challenges that they face every day as they try to fulfill work and/or family responsibilities. The respondents gave a current description of the development of the Anishinabe family structure and the changing roles and responsibilities of grandparents. They were straightforward in discussing their perceptions (good and bad) of how diabetes was affecting their relationships with grandchildren. The research results also conveyed positive messages of the strength and resiliency of this group, as eight respondents were managing their diabetes for a period of 11 to 24 years.

Limitations

My personal life experience as a First Nation's person and my professional background as a social worker led me to believe that my time frame to conduct the interviews would pose a challenge. I knew that the cultural ethical principle of respect for elders and grandparents as teachers would form the basis of our interaction. The information they shared with me would not happen in accordance with clock time. The time that we would spend together would depend on the mutual understanding of shared ideas.

Another limitation was obtaining traditional philosophical concepts from participants who are bilingual since the researcher cannot speak the Anishinabe language. Unfortunately the rich descriptive concepts and nuance available in the Anishinabe language was not captured as these interviews of necessity were conducted in English and framed in contemporary meanings.

A third limitation related to the researcher's professional background as a social worker. It was speculated that if participants knew that I was a social worker they may be reluctant to openly express their views and feeling about aspects of the child welfare system or about current family problems since a large percentage of Aboriginal people have been negatively affected by this system. Although I am of First Nations descent and can be located socially in the community, as a social worker I am viewed to a large extent by the Aboriginal community as a representative of the state who has the power to separate families. This has the potential of affecting a relationship of trust between the researcher and participant.

A fourth limitation is that the sample size was small; however, a rich data set was obtained, allowing the researcher to learn what issues were important for these grandparents. The sample was also urban-based and nonrandom, which represented the perceptions of 10 Anishinabe grandparents. Most of the respondents who volunteered for the study had some form of diabetes education and were making healthier lifestyle choices. The small sample size provided a limited range of human experience affecting a large Aboriginal population making it unfeasible to form generalizations.

Implications and Directions for Future Research

A further study could investigate the correlation between cultural retention and grandparents' traditional child rearing practices to see if traditional child rearing practices are more intact in reserve communities than urban areas. More research conducted on Anishinabe people, who reside on reserves, with high prevalence of diabetes, could help explain the factors that are contributing to the high diabetes rates. Such a study could also compare whether positive health outcomes are related to cultural retention,

education, employment and the availability of health related services and resources. Additional questions also need to be asked to determine the respondents' health beliefs and to find the sources from which they received support. Other questions could give more contextual background information to the social, cultural and environment changes that occurred to Anishinabe people, such as "Did your parents or grandparents attend residential school?" and, "Were you or your parents and grandparents affected by the child welfare system?" Given respondents' ideas expressed in this study, it is likely that future research will show that these two systems had the greatest impact on changing Anishinabe family life.

REFERENCES

Abonyi, S. (2001). *Sickness and symptom: Perspectives on diabetes among the Mushkegowuk Cree*. Unpublished Thesis For The Degree Doctor of Philosophy, McMaster University, Hamilton, ON, Canada.

Aboriginal Diabetes Association. (2002). *Diabetes fact sheet*. [Brochure]. Ottawa, ON: Health Canada.

Adams, H. (1995). *A tortured people: The politics of colonization*. Penticton, B.C.: Theytus Books.

Alphonso, C. (2003, December 10). Grandparents take active role in households. *The Globe and Mail*, p. A5.

Baum, W. K. (1995). *Oral history for the local historical society*. Walnut Creek, CA: AltaMira Press.

Bishop, W. (1999). *Ethnographic writing research: Writing it down, writing it up, and reading it*. Portsmouth, NH: Boynton/Cook Publishers.

Blanchard, E. (1977). *Extended family: Parental roles and child rearing practices*. Arizona, USA: Publisher Unknown.

Bobet, E. (1997). *Diabetes among first nations people*. Ottawa, Canada: Health Canada.

Boss, P. (2002). *Family stress management*. Newbury Park, CA: Sage Publications.

Bruyere, J. & Garro, L. (2000). Nehinaw (Cree) understanding of diabetes: "He travels in the body." *Canadian Nurse, 96(6),* 25-28.

Cajete, G.A. (1999). *Igniting the sparkle: An indigenous science education model*. Shyand, NC: Kivaki Press.

Canadian Diabetes Association (2003). *Commonly used diabetes pills: An overview*.

Toronto, Ontario [Brochure].

Canadian Diabetes Association. (July 18, 2000). *Diabetes: A Manitoba strategy, a Manitoba health publication*. Winnipeg, MB: Manitoba Health [Brochure].

Chaddock, B. (1998). Diabetes: A threat to first nations people but one that can be managed. *In Touch*, 9, (1), 11-14.

Cianci, D. & Nadon, S. (1987). *Walking the medicine wheel path in daylight: An exploration of the medicine wheel teachings on human relationships*. Owen Sound, ON: The Maplestone Press.

Cyr, R. A. (1998). Talking with elders about diabetes: Dealing with the mental-emotional and spiritual aspects. *In Touch*, 9(1), 15-18.

Diabetes: What is it, what it costs, what is working. (2000) *In Touch. 16*, Ottawa: The National Indian & Inuit Community Health Representatives Organization. 1-38.

Ellerby, J. H., McKenzie, J., McKay, S., Gariepy, G. J., & Kaufert, J. M., (2000). Bioethics for clinicians: Aboriginal cultures. *Canadian Medical Association Journal, 163*(7), 845-850.

Evers, S. (1987). Epidemiological methods in diabetes research. In T. Kue Young (Ed.), *Diabetes in the Canadian native population: Biocultural perspectives.* Toronto, Canada: Canadian Diabetes Association. 181-191.

Fagg, W. (1970). *The tribal image: Wooden figure sculpture of the world.* London, England: Trustees of the British Museum.

Friesen, G. (1984). *The Canadian prairies: A history*. Toronto, ON: University of Toronto Press.

Garro, L. (1987). Cultural knowledge about diabetes. In T. Kue Young (Ed.), *Diabetes in the Canadian native population: Biocultural perspectives* (pp. 97-110). Ottawa, Canada: Health and Welfare Canada.

Garro, L. (1989). Understanding diabetes in its cultural context: A case study of a Manitoba Ojibway community. *Manitoba Medicine* (Fall), 94-96

Gochman, D. S. (1988). Cultural determinants. In D. S. Gochman (Ed.), *Health behavior: Emerging research perspectives* (pp. 243-248). New York: Plenum Press.

Grant, A. (1996). *No end to grief: Indian residential schools in Canada*. Winnipeg, MB: Pemmican Publications.

Graveline, F. J. (1998). *Circle works: Transforming eurocentric consciousness*. Halifax, NS: Fernwood Publishing.

Gregory, D., Whalley, W., Olson, J., Bain, M., Harper, G., Roberts, L., & Russell, C. (1999). Exploring the experience of type 2 diabetes in urban aboriginal people. *Canadian Journal of Nursing Research, 31*, 101-115.

Grills, S. (Ed.) (1998). *Doing ethnographic research: Fieldwork settings*. Thousand Oaks, CA: Sage Publications.

Grzywacz, J. & Fuqua, J. (2000). The social ecology of health: Leverage points and linkages. *Behavioral Medicine, 26*,(3), Retrieved on December 2, 2003, from http://ingotrac.galegroup.com.

Hagey, R. (1987). Rationality of responses among native diabetics. In T. Kue Young (Ed.), *Diabetes in the Canadian native population: Biocultural perspectives* (pp. 111-122). Ottawa, ON: Health and Welfare Canada. 111-122.

Hart, E. (1995). *Getting started in oral traditions research*. Prince of Wales Northern

Heritage Centre: Government of the Northwest Territories.

Hart, M. (2002). *Seeking mino-pimatisiwin: An aboriginal approach to healing*. Halifax, NS: Fernwood Publishing.

Hoops, J. (1979). *Oral history: An introduction for students*. Chapel Hill, NC: The University of North Carolina.

Hudson, P. & McKenzie, B. (1981). Child welfare and native people: The extension of colonialism. *The Social Worker, 49*(2), 63-88.

Human Resources Development Canada, (2002). *Aboriginal people in Manitoba*. Winnipeg, MB: Her Majesty the Queen in Right of Canada.

Ing, N.R. (1991). The effects of residential schools on native child rearing practices. In V. Kirkness & C. Urion (Eds). *Canadian Journal of Native Education, 18*, 65-118.

Johnson. J. C. (1990). *Selecting ethnographic informants: Qualitative research methods. 22*, Newbury Park, CA: Sage Publications.

Kewayosh, A. (1993). The changing picture – Diabetes in first nations in Canada. Report on the *Second International Conference on Diabetes And Native Peoples: "Sociocultural Approaches In diabetes Care For Native Peoples"* (pp. 19-28). Honolulu, HI: Ottawa, Assembly of First Nations, First Nations Health Commission.

Lederman, J. (1999). Trauma and healing in first nations communities. *Native Social Work Journal, 2*(1), (pp. 59-90). Sudbury, ON: Laurentian University Press.

Leonard, K. & Kinoshameg, R. (2003). *Pathway to wellness: Aboriginal diabetes handbook for community health workers*. Winnipeg, MB: National Aboriginal Diabetes Association.

Longclaws, L. (1994). Social work and the medicine wheel framework. In Beulah A. Compton & Burt Galaway (Eds.), *Social work processes.* (pp. 24-33) Pacific Grove, CA: Brooks/Cole Publishing Company.

Maclean, H. & Oram, B. (1988). *Living with diabetes: Personal stories and strategies for coping.* Toronto, ON: University of Toronto Press.

Malloch, L. (1989.). Indian medicine, Indian health. *Canadian Woman Studies, 10*(2/3), 105-112.

Meadows, K. (1990). *The medicine way: A shamanistic path to self-discovery.* Shaftsbury, Great Britain: Element Books.

Miller, J.R. (1996). *Shingwauk's vision: A history of native residential schools.* Toronto, ON: University of Toronto Press.

Peers, L. L. (1987). *An ethnohistory of the western Ojibwa, (1780-1830).* Unpublished Master's Thesis. University of Manitoba, Winnipeg, Manitoba, Canada.

Ray. A. J. (1998). *Indians in the fur trade: Their role as trappers, hunters and middlemen in the lands southwest of Hudson Bay 1660-1870.* Toronto, ON: University of Toronto Press.

Reimer, D., Mattison, D., & Specht, A. (Eds.) (1984). *Voices: A guide to oral history.* Victoria, BC: Ministry of Provincial Secretary and Government Services Provincial Archives.

Rosenthal, C. J. & Gladstone, J. (2000). *Grandparenthood in Canada: Contemporary family trends.* Ottawa, ON: The Vanier Institute of the Family.

Sanders, C. (2003, December 10). Grandparents raising growing number of kids. *Winnipeg Free Press.* Winnipeg: Andrew S. Ritchie.

Schensul, J. J., LeCompe, M. D., Hess Jr., G. A., Nastasi, B. K., Berg, M. J., Williamson, L., Bretcher, J. & Glasser, R. (1999). *Using ethnographic data: Interventions, public programming, and public policy*. Walnut Creek, CA.: AltaMira Press.

Shestowsky, B. (1993). *Traditional medicine and primary health care among Canadian aboriginal people*. Ottawa, ON: Aboriginal Nurses Association of Canada.

Ship, S. (1998). Diabetes and aging in aboriginal communities. *In Touch*, 9(1), 5-10.

Skinner, P., & Silverman-Peach, D., (1989). *Diabetes and native-Americans: Socio-cultural change, stress and coping.* National Institute on Disability and Rehabilitation Research, U.S. Department of Education. No. G0083094.

Statistics Canada (2001). *Aboriginal peoples survey 2001-initial findings: Well-being of the non-reserve aboriginal population.* Retrieved October 21, 2003, from http://www.statcan.ca.

The National Indian & Inuit Community Health Representatives (2000). Diabetes. *In Touch, 16,* 1-38.

Van Kirk, S. (1993). *Many tender ties: Women in fur-trade society, 1670-1870.* Winnipeg, MB: Watson & Dwyer.

White, J. M., & Klein, D. M. (2002). *Family theories*. Thousand Oaks, CA: Sage Publications.

Whitecap, L. (1988). The education of children in pre-European plains America. *Canadian Journal of Education, 18*(2), 33-40.

Wilson, R. I. (1994). *Medicine wheels: Ancient teachings for modern times.* New York:

The Crossroad Publishing Company.

Young, R. S. (1987). *Diabetes and the American Indian: A review of current treatment strategies*. Tucson, AZ: Native American Research & Training Centre.

Young, T. K. (1988). *Health care and cultural change: The Indian experience in the central subartic*. Toronto, ON: University of Toronto Press.

Young, T. K., Reading, J., Elias, B. & O'Neil, J. D. (2000). Type 2 diabetes mellitus in Canada's first nations: Status of an epidemic in progress. *Canadian Medical Association Journal, 163(*5). Retrieved November 12, 2003, from http://www.cmaj.ca.

Appendix A

Native Telecommunications Inc.

Radio Advertisement to Recruit Participants

University of Manitoba

Hello, my name is Diane McDonnell.

If you are an Anishinabe grandparent, have type 2 diabetes, are 50 years or older, live in Winnipeg, and would like to participate in a University of Manitoba research interview, please call (204) 794-0433 for information. An honorarium will be offered.

Meegwetch.

Appendix B

Letter to Obtain Informed Consent

UNIVERSITY OF MANITOBA

Faculty of Human Ecology

Department of Family Studies

35 Chancellor's Circle
Winnipeg, Manitoba
Canada R3T 2N2
Phone: (204) 474-9794

Anishinabe grandparents living with diabetes have a range of life experiences. Each person's experience is unique. I would like to ask you about how diabetes affects your life and your relationships with family and community. Your story can help to draw attention to the ways diabetes affects families. If you tell your story it can help understand the challenges and opportunities you have as a grandparent with diabetes. By talking to several Anishinabe grandparents with diabetes I hope to understand these issues and explain my findings in a report.

If you agree to an interview, it will take about one to two hours of your time. You will be asked questions about your thoughts and feelings related to your grandparent experiences. The information that you provide will be kept confidential. Your name will not appear in the study. You can choose not to answer any question at any time, ask for clarification, or end the interview at any time if you wish. After I put your story together with others, I will destroy the information you gave me.

I am a First Nation graduate student at the University of Manitoba. As part of completing a degree in Family Studies, I am undertaking this project. If you are not satisfied with the conduct of the interviewer or the process, your inquires can be directed to the Family Studies Department Head at 474-9225 or to Carol Harvey, my advisor, at 474-9794. Meegwetch.

Sincerely,

Diane McDonnell, BSW
Master's Student

Carol D.H. Harvey, Ph.D.
Professor of Family Studies

Appendix C

Written Consent Form

UNIVERSITY OF MANITOBA

Faculty of Human Ecology

Department of Family Studies

35 Chancellor's Circle
Winnipeg, Manitoba
Canada R3T 2N2
Phone: (204) 474-9794

Research Project Title: Anishinabe Grandparents: Perceptions of Living With The Effects of Type 2 Diabetes

Researcher: Diane McDonnell

I, _____, understand that I am being asked to take part in a study conducted by Diane McDonnell, a graduate student in the Master of Science program of the Faculty of Human Ecology – Family Studies Department at the University of Manitoba. The study will examine how Anishinabe grandparent's diagnosed with type 2 diabetes perceive their roles and responsibilities in child rearing. The research is intended to enhance knowledge about First Nation family life.

Diane McDonnell will ask me questions on my thoughts and feelings related to my grandparenting experiences. I understand that the interview will take one to two hours and that I may choose to have my answers audiotaped or written down by the researcher. I understand that the researcher will respect my right to privacy and will keep the audiotaped or written interview in a secure place and keep my name confidential. I

understand that my information to the researcher will be destroyed following the printing of this study. I understand that as a participant that I have certain rights.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. It you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The Joint-Faculty Research Ethics Board has approved this research at the University of Manitoba. I understand that if I have any concerns or complaints regarding any of the procedures, I may contact the Human Ethics Secretariat at (204) 474-7122 or Head of the Department of Family Studies, Dr. Joan Durrant at (204) 474-9225, the advisor Dr. Carol Harvey at (204) 474-9794, or the researcher at ( )

I understand the above information regarding participation and agree to participate in this study.

Signature _____ Date _____

Signature of researcher _____ Date _____

Appendix D

Interview Guide

Let's start by you telling me a little bit about yourself.

Personal History:

1. What is your full name?
2. In what year were you born?
3. Where did you spend your childhood?
4. (a) Where did (do) you work?

   (b) What is your job?

   (c) How many hours per week do you work?

Interviewee's Family of Origin:

5. (a) What are your parent's names?

   (b) From where did your mother and father come?

   (c) How did they meet?
6. In what kind of a family household did you grow up? [Possible probes: Single parent, both parents, no parents, extended family, foster home]
7. Did your parents have diabetes?
8. (a) How many brothers and sisters do you have?

   (b) How many are living?

   (c) Do any of your brothers or sisters have diabetes?

Interviewee's Immediate Family:

9. What is your marital status now?
10. (a) How many children do you have?

(b) How old are they? [Probe for number of sons and number of daughters]

(c) Where do they live?

Interviewee's Grandchildren:

11. (a) How many grandchildren do you have?

(b) How many are girls?

(c) How many are boys?

12. How old are they?

13. Where do they live?

14. How often do you see them?

Information on Grandparenting:

15. Did any of your grandparents have diabetes?

16. Who prepared you for your responsibilities as a grandmother/grandfather?

17. Tell me about any traditional or cultural teachings on 'grandparenting' that you may have received.

18. How does your diabetes affect your relationships with the grandchildren?

19. Describe some activities your grandparents did with you.

20. (a) What do you do with your grandchildren that are similar to what your grandparents did for you?

(b) What do you do with your grandchildren that are different from what your grandparents did for you?

21. Are there any influential persons or life events that helped you be a grandparent? [Possible probes: Good grandparenting when I was a child; strong husband/wife; cooperative offspring]

22. Are there any things that keep you from being an active grandparent? [Probes: Residential school, foster families, early deaths of offspring]

Information on Interviewee's Health Status and It's effect on Carrying out Grandparent Roles and Responsibilities in Child Rearing:

23. When were you diagnosed with type 2 Diabetes?

24. Describe the different ways in which you have to manage your diabetes.

25. How do you take care of yourself?

26. Are you able to be the grandparent you want to be?

27. If you could change anything about being a grandparent, what would it be?

28. Is there anything else that you would like to say?

Additional Questions to Explore:

How far did you go in school?

Do you own a car?

Do you drive?

Do you own your home?

Are you renting your home?

Appendix E

Would you like to receive a two-page research summary? ___ Yes ___ No

Name: _____

Address: _____

_____