Nurses and Human Resources In Indian Communities: Nurse Perceptions Of Factors Affecting Collaboration With Elders And Contact With Traditional Healers On Indian Reserves And In Health Centres In Manitoba

by

David Michael Gregory

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NURSES AND HUMAN RESOURCES IN INDIAN COMMUNITIES: NURSE PERCEPTIONS OF FACTORS AFFECTING COLLABORATION WITH ELDERS AND CONTACT WITH TRADITIONAL HEALERS ON INDIAN RESERVES AND IN HEALTH CENTRES IN MANITOBA

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ABSTRACT

Previous nursing research has not examined the extent of collaboration between nurses and Indian Elders, and contact with traditional healers in Manitoba. An exploratory-descriptive two phase research design was implemented to identify factors affecting collaborative efforts between nursing staff and Indian Elders, and to explore nurse-healer interaction. Phase I consisted of semi-structured, face to face interviews with field nurses (N=10) and Elders (N=13) on three Indian reserves in northern Manitoba. Phase II consisted of a close-ended, structured, census survey mail questionnaire administered to nurses (N=64) working autonomously with Indian clients. Findings based on Phase I interviews and an 81.2% return rate of Phase II questionnaires indicated that nurses who were appreciative of the traditional health care system were collaborating with Elders and healers on reserves and health centres in Manitoba. The need for ongoing and indepth communication between nurses and Elders/healers was established. A more detailed cultural orientation was indicated as needed by the majority of nurses. Factors influencing the collaborative process were identified as: past transcultural experiences, knowledge of who/what Elders are, influence of the nurse's own culture and the attitude of the Elders and community towards the nurse. Client conditions identified as appropriate for Elder referral included: lack of self worth, family discipline problems, social interaction problems, child neglect, and parent-child conflict.

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To the memory of my mother

To my father who has always offered me love
and endless support in all that I do

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Chapter I

STATEMENT OF THE PROBLEM

A cultural and linguistic revival is taking place on Indian reserves in Canada (Adams, 1984). One area of Indian cultural renaissance is health care, specifically the utilization of traditional practices (Government of Canada, 1983). In areas where traditional Indian health practices have been attenuated, attempts are being made to restore traditional ways. For example, in the Kenora region of northwestern Ontario, traditional healing practices were not formally available and the local Indian people identified a need for these services. Medicine men were brought to this area in order to resurrect traditional practices and provide ongoing educational assistance (University of Manitoba Medical Journal, 1982). This resurgeance and revitalization of traditional Indian health care practices presents the nursing profession (and other health care professionals) with a significant challenge in providing quality client-centred health care.

Holistic nursing care incorporates and supports the client's cultural beliefs and values. Transcultural nursing, a subfield of the profession, espouses the provision of culture-specific nursing care. Leininger, who

was instrumental in the development of this subfield, has defined transcultural nursing as "a formal area of study and practice focused on a comparative analysis of different cultures and subcultures...with respect to cultural care, health and illness beliefs, values and practices" (1978, p. 8). Leininger acknowledged the challenge to help nurses, physicians and other professional personnel to realize that clients possess their own healing and care modes, which may be as effective as some current professional or scientific acts. She also predicted that "demands for cultural rights in health services will increase markedly in the future, and will place greater demand on nurses and physicians to go beyond mind/body treatment" (Leininger, 1984, p. 73).

This prediction has been recently actualized in Manitoba. The northern Manitoban Chiefs have requested that traditional Indian medicine be included in the Health and Welfare Canada services offered on their reserves. A resolution passed by the Chiefs and representatives of 25 bands of the Manitoba Keewatinowi Okimakanak Incorporated (MKO) stated that since "the department's [Medical Services] normal services do not cure all the ills of the Indian people, traditional medicines should be made available" ("Traditional Medicine", 1984).

Thus, nurses who are providing primary health care to Indian clients in Manitoba (Spencer, 1984) and elsewhere in Canada, need to be aware of and understand traditional

Indian beliefs and practices if a holistic nursing approach is to be sustained. This knowledge would enable nurses to work effectively with Indian clients and offer services which may be lacking or ineffective in the dominant health care system. As primary health workers, nurses provide comprehensive care and assist individuals and families to make appropriate use of the services of physicians and other professionals (Henderson, 1983). It is within this role that nurses possess the opportunity to acknowledge traditional healing systems.

Health care providers within the Indian health system range from the Elders to socially sanctioned healers. Scant research has been conducted in this area and a paucity of information exists regarding traditional Indian healing practices on reserves and health centres in Manitoba. No current abstracts examining the extent of contact and interaction between nurses and traditional healers were identified in the literature review. Key Indian informants were contacted and the investigator was advised that ethnomedicinal practices are being carried out to varying degrees on reserves and health centres within the province.

The health care profession has traditionally maintained a suspicious and often skeptical stance regarding indigenous healers and their health care systems. Recent literature indicated a profound but cautious change in attitude. Given the minimal documentation of traditional Indian health care

practices within the province of Manitoba, and the hesitancy on the part of the Federal Government to actively promote and enhance collaborative/interactive relationships between health care workers and traditional healers, this study focused on factors affecting collaborative efforts (actual and potential) between nursing staff and Indian Elders. The utilization of Elders as health resource persons was explored, as well as the extent of contact between nurses and traditional healers. It should be noted that many Indian Elders are also traditional healers, thereby limiting attempts to formally dichotomize subject groups as strictly Elders or traditional healers.

A booklet produced by Health and Welfare Canada (Medical Services Branch, Pacific Region) entitled, The Teaching of the Elders, (1982), offered insight into the social and cultural importance of Indian Elders. As noted in the booklet's introduction, Elders "are the teachers of our [Indian] culture" (p.1). The booklet demonstrated that Elders were a legitimate source of knowledge and cultural information. Couture (1979) stated that "Elders are superb embodiments of highly developed human potential", and praised their qualities; "intuition, intellect, memory, imagination...their profound and refined moral sense...a high level of spiritual/psychic attainment..." (p. 7). This author urged that Elders be given careful attention and possible emulation. It is the Elders' self-actualization

that offers potential for native health programs and for the full range of native educational development (Couture, 1979).

The employment of an Elder in a native alcohol treatment centre (Poundmaker's Lodge in Edmonton) was noted by Grescoe (1977). The Elder was described as "wise in Indian culture" and "conduct[s] traditional pipe ceremonies and advise[s] troubled youngsters" (p. 121). The counselling role of Elders has also been documented and advocated by Rodgers:

> elders are important people...suffice to say that some native traditional leaders and elders have an excellent grasp of psycho-social dynamics and are respected as counsellors in the communities, even by the "modern generation" to some extent (Rodgers, No date, p. 10).

The Shamattawa Indian Band in northern Manitoba, which has experienced severe solvent abuse (sniffing) has, as part of their community development, engaged Elders in the treatment of their young people (Menary, 1979). Although limited, the literature identified Elders as a valuable resource in terms of counselling and guidance, preservation of culture, and the survival of Indian People.

The term Elder does not automatically ascribe advanced age status to the identified individual. One "becomes" an Elder through actions/advice which demonstrate wisdom and good judgment sense. Elders assist the Indian People in survival and actively contribute to the community in some capacity. It would appear that the majority of Elders are

senior citizens though, and this has significant ramifications for nursing personnel.

Most of the social science research conducted on non-Indian elderly persons focuses on this group as passive beneficiaries who act as a drain on the energy and resources of those closest to them (Stueve, 1983). In an elegant investigation, Stueve examined the role of the elderly as active members in informal and formal social networks. She concluded that "many elderly still have much to offer age peers and other generations in their role as family members, friends, neighbors, natural helpers, and volunteers" (p. 83). This fresh perspective on the elderly is difficult to formulate since "...characterization of the elderly as active network contributors and community participants is out of step with many of our cultural images and beliefs about old age" (Stueve, 1983, p.60).

Northern nurses therefore face several challenges in the collaborative process with Elders as health resource personnel. First, they may have to overcome stereotypes of the aged; and second, they are treating clients who in certain instances may benefit from counselling sessions with individuals who are members of the non-formal health care system. This second challenge is based on the premise that the client will be receptive to counselling provided by the Elder(s), and the practitioner's recognition and appreciation for the alternate health care system.

Recognition and appreciation of the alternate health care system is also fundamental in determining the intensity of interactions between nurses and traditional healers.

It is not suggested that all Indian people would be comfortable with counselling sessions provided by the Elders. Nurses would have to be sensitive to clients and assess whether a referral to an Indian Elder would be an acceptable practice. As well, not all Elders may be comfortable in counselling community members and nurses would have to establish which Elders are supportive of a client counselling role.

The questions which guided this research were:

1. What factors are perceived by nursing personnel as affecting collaboration (actual or potential) with Indian Elders in terms of counselling clients?
2. What is the extent of knowledge nurses possess regarding the role of Elders in community health?
3. Are nurses currently involved in the referral of Indian clients to Elders?
4. Have the referrals to Elders been successful in terms of client functioning?
5. To what extent and how are Indian communities sharing knowledge of traditional healers and Elders with their nurses?

6. What is the extent of contact between nurses and traditional healers?
7. What are the existing client referral patterns to traditional healers?

Nurses working as primary health care workers could contribute significantly towards quality of care by referring clients to traditional healers or Elders when warranted. This practice would enhance the holistic approach which the nursing profession advocates and would assist Indian clients in preserving and developing their own health values. This study was directed towards gaining knowledge regarding transcultural nursing practices on Indian reserves and health centres in Manitoba. Specifically, factors influencing the collaborative efforts between nurses and Elders in terms of client counselling were examined. As well, the extent of nurse-traditional healer contact was explored. Traditional Indian medical practices were not explored, nor actively sought from research subjects.

Chapter II

CONCEPTUAL FRAMEWORK

Three theoretical perspectives were integrated to form the conceptual framework for this research. These included:

1. Adaptation In Cultural Evolution (Alland, 1970);
2. The Sociology of Perception (Douglas, 1982);
3. Interaction Goals As Bases Of Inference In Interpersonal Perception (Jones, E., and Thibaut, J., (1958).

Alland (1970) developed a system's perspective of cultural development while at the same time embracing concepts of biological evolution. Cultural development or evolution has been identified as an opportunistic process and is capable of rapid change in both quality and direction. It involves the development of stable systems which are maintained through negative feedback. Negative feedback has been identified as one of the major forces in the cultural evolutionary process. Stability in systems reflects the conservative force of adaptation in which systems maintain themselves through time. Alland's concepts were applied with regards to the relationship between the traditional Indian health care system and the dominant Western health care system.

The dominant western health system aided by environmental (smallpox, tuberculosis, etc.), political (establishment of the reserve system, B.N.A. Act, etc.), and religious events (conversion of the Indian tribes to Christianity), served to abate and erode the existing traditional healing systems over time (Cardenas & Lucarz, 1985). Alland posited that "populations carrying more efficient systems replace or absorb populations carrying less efficient systems if such groups are competing for the same environment" (1970, p. 180). As O'Neil (1981) noted with the Inuit, cosmopolitan medicine demonstrated an ability to reduce morbidity and mortality significantly and because of this, the Inuit accepted its benefits. This observation can be logically applied to the Indian people as well. The traditional healers could not compete with the powerful and apparently effective western health care system. As a result of this occurance, a massive wave of diffusion was initiated, with the major "flow" originating from the western health system and severely diluting the traditional healing system.

At present, the Indian people are experiencing a cultural renaissance. It is within this growth process that Indian people are voicing their concerns regarding the western health system. They are claiming this system is not adequate in coping effectively with many of the ills of their (Indian) society. Jilek (1982) identified that it is not due to the lack of modern treatment services that a

revival of indigenous healing ceremonials has occurred. "It has to do with a lack of culture-congenial and holistic approaches in modern medicine" (p. 161). In general terms, the dominant health care system is currently being perceived as a less effective system. Health statistics available from Indian Affairs and Northern Development (1980) in Indian Conditions: A Survey, document the foundations for these perceptions.

According to Sahlins and Service (1960), "[a] cultural system which more effectively exploits the energy resources of a given environment will tend to spread in that environment at the expense of less effective systems" (p. 75). Thus, it is proposed that a second major wave of diffusion is taking place, a century or more following initial cultural diffusion. This "wave", with its emphasis on traditional Indian values, can be viewed as an attempt to ensure Indian survival. Currently, the "flow" is originating at the grass roots level and is pervading the dominant health care system: Medical Services.

The Indian people, as recipients and consumers of health care have identified a deficit in the existing health care system. Due to a vast array of complex factors (economic, political, ecological, social and cultural), the Indian people find themselves in a state of disequilibrium. This state of disequilibrium is requiring additional energy costs in terms of system functioning and as a result, Indian

people are now requesting options in conjunction with the western health system in order to compensate for some of these costs. Traditional medicine is being created anew in order to cope with the problems and stresses that plague Canada's indigenous people. The traditional medicine that is resurfacing however, has undergone evolutionary changes and development and is not simply a direct copy or duplication from earlier times. Recent interests in traditional Indian culture and healing are being invested in order to maximize survival and minimize destructive forces. Elders are being approached by an increasing flow of Natives seeking advice and counsel, healing and inspiration, interpretation of the past and present which are the prerequisites for future survival (Couture, 1979).

It is naive and unrealistic to propose that a complete replacement of the existing health system by a traditional healing system would take place. A blending or melding of the two systems is more likely to transpire. This scenario was acknowledged by the Department of National Health and Welfare which stated that:

> a combination of traditional practices and western medicine could be a powerful force for healing particularly those illnesses caused by the intolerable social environment in many Indian communities as evidenced by high rates of violence...It could also be a positive step in the enhancement of Indian culture and traditions and in the re-awakening of pride in Indian achievement (Canada, 1980, p. 72).

Alland suggested that cultures undergo evolutionary changes as a result of system interface. In other words, cultural evolution transpires as a result of various system interactions. Suffice to note that this process is indeed complex and a detailed examination is beyond the scope of this thesis. Four key systems involved in the nurse-client referral process to Elders have been identified. They included:

1. the nursing profession
2. Indian communities
3. the dominant health care system (Medical Services)
4. the indigenous health system (traditional healers and Elders)

The goal of transcultural nursing interventions is to assist clients in attaining health equilibrium based on the provision of culturally oriented nursing care. The practice of transcultural nursing with respect to Indian clients is accomplished through an intimate understanding of the identified key systems. That is, a working knowledge of the structure, function and relationships of the key systems is essential in the delivery of transcultural nursing care. Scrutiny of this system interface provided the opportunity to integrate the various theoretical perspectives (Alland, Douglas, Jones and Thibaut) in order to examine nurses' perceptions of factors influencing collaboration with Indian Elders.

Douglas (1982), in The Sociology Of Perception suggested that anything which is perceived must pass through perceptual controls. Data is admitted; some may or may not be rejected; and some is supplemented to make the event cognizable. The process is largely cultural. Cultural input therefore, plays a major role in the perception process, and consequently a nurse's cultural orientation will shape perceptions of factors which influence his/her decision making. Douglas attempted to systematize cultural constraints. She developed a two dimensional group-grid model which reduces social variation to only a few grand types. The author stated that there are two dimensions of control over the individual:

1. group commitment: strength of allegiance to a group (For example, a learned profession) and,
2. every remaining form of regulation. This is the grid component. (For example, laws, policies etc.)

Combined, four extreme visions of social life are produced.

HIGH GRID Atomized Subordination (B)	Ascribed Hierarchy (C)
(A) Individualism LOW GRID LOW GROUP	(D) Factionalism HIGH GROUP

Thus, there are four possible social environments in which an individual may be found.

1. (A) Low grid/low group: Allows options for negotiating contracts or choosing allies and in consequence, it also allows for individual mobility up and down whatever the current scale of prestige and influence. (Individualism)
2. (B) High grid/low group: Ascribes closely the way an individual may behave. They do as they are told without the protection and privileges of group memberships. (Atomized subordination)

3. (C) High grid/high group: Environment of large institutions where loyalty is rewarded and hierarchy is respected. An individual knows his/her place in a world that is securely bounded and stratified. (Ascribed Hierarchy)
4. (D) Low grid/high group: Defined by a form of society in which only the external group boundary is clear. (Factionalism)

The ascribed hierarchy cell (C) is of particular interest. Medical Services nurses function within a bureaucratic institution where loyalty is rewarded and hierarchy is respected. In terms of Douglas' framework, this group possesses a mutual commitment and is highly regulated. Thus, the characteristics of the individuals identified in the ascribed hierarchy cell appear to be appropriate and relevant to the providers of Indian health care (nurses).

Jones and Thibaut (1958) proposed that an individual interacts with three kinds of goals:

1. Facilitation of personal goals: Promotes the arousal of value-maintenance.
2. Deterministic analysis of personality: Social, physical and biological determinants cause an individual to behave as he now does. (Causal-genetic set)