

Importance de l'autochtonicité : Influence de l'identité des Amérindiennes sur leurs décisions en matière de santé

Mary K. Canales

Les Amérindiennes font face à des injustices sur le plan de la santé physique, mentale, et de la spiritualité. Bien que cette étude ait pour but d'examiner le processus de prise de décision chez les Amérindiennes du Nord-Est des États-Unis en ce qui concerne la mammographie, le rôle joué par l'identité autochtone dans les décisions prises en matière de santé en général a été jugé suffisamment significatif pour faire l'objet d'un rapport distinct. Les résultats d'une étude théorique à base empirique effectuée auprès de 20 Amérindiennes a servi de base à une analyse des complexités entourant la question de l'identité et de la prise de décision en matière de santé. Le thème de l'importance de l'autochtonicité reflète l'influence au plan individuel et collectif de l'identité autochtone sur les décisions prises par les femmes en matière de santé. Le document traite de ses répercussions pour les chercheurs et les cliniciens, notamment les liens entre les événements historiques et la construction de l'identité actuelle, la nature fluide de l'identité et l'impact du racisme sur les décisions relatives à la santé.

Mots clés : Amérindienne, prise de décision, théorie à base empirique, identité, Autochtone, racisme, femmes

Connecting to Nativeness: The Influence of Women’s American Indian Identity on Their Health–Care Decisions

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American Indian women experience health inequities within the physical, mental, and spiritual realms. Although the purpose of this study was to examine mammography decision-making processes among Native women in the north-eastern United States, the role of Native identity in health-care decision-making in general was identified as significant and is therefore being reported independently. The findings of a grounded theory study with 20 American Indian women formed the basis for an examination of the complexities surrounding identity and health-care decision-making. The theme of Connecting to Nativeness reflects the individual and communal influences of Native identity on women’s health and health-care decisions. Implications for researchers and clinicians, including the relationship between historical events and current constructions of identity, the fluid nature of identity, and the impact of racism on health-care decisions, are addressed.

Keywords: American Indian, decision-making, grounded theory, identity, Native, racism, women

Introduction

“A woman’s identity in traditional Indian life was firmly rooted in her spirituality, extended family, and tribe” (LaFromboise, Heyle, & Ozer, 1990, p. 457). Women conveyed cultural knowledge to younger generations and cared for their children and relatives. Although women in traditional Native cultures are perceived as the “givers of life,” their own health is increasingly threatened (Grace, 2003).

According to recent data from the United States (Centers for Disease Control and Prevention, 2003), “American Indian communities bear a greater burden of health risk factors and chronic disease than other racial/ethnic minority populations” (p. 2). For example, prevalence rates for hypertension, elevated blood cholesterol, cardiovascular disease, and diabetes are higher in this population than in other racial/ethnic minorities. In addition, American Indian women bear a disproportionate cancer burden, with the lowest survival rates of any racial group in the United States (Risendal, Dezapien, Fowler, Papenfuss, & Giuliano, 1999).

Considering that data-collection mechanisms often misclassify and consequently under-report disease prevalence (Hampton & Friedell, 2001), these inequities are particularly alarming; more American Indians may be at risk or in need of care than is currently thought.

Aboriginal peoples in Canada suffer similar inequities. According to a recent report released by the Canadian Population Health Initiative, Aboriginal people in Canada can expect to live 10 years less than non-Natives, on average, and infant mortality rates in Indian and Inuit communities are three times the national average (Picard, 2004). In addition, Aboriginal women in Canada are disproportionately affected by chronic conditions. For example, Registered Aboriginal women in Ontario are more likely than the general population of women to die as a result of alcoholism/cirrhosis, motor vehicle crashes, pneumonia, homicide, suicide, and diabetes (Grace, 2003). Also, cervical and gallbladder cancer rates are 73% and 50%, respectively, higher in Aboriginal women than in the general population of women in Ontario (Grace).

In addition to these physical disparities in health, some Native women have experienced an "idiom of loss," feelings of distress related to a loss of moral relations with persons, community, and the land (Willms et al., 1992, p. 331). In their research with Native women of the Nishnawbi-Aski Nation of Northern Ontario, Willms and colleagues report that the women experienced a profound sense of loss, a "grieving for lost traditions, dreams and hopes" (p. 332). The women's physical, mental, and spiritual health was compromised by the rapid changes occurring within and outside their Native community. Yet despite these heavy burdens, the Nishnawbi-Aski women carried on in the hope that their continued engagement with the community would lead to positive change.

Many Native women experience health inequities within the physical, mental, and spiritual realms. Research that focuses strictly on physical health inequities ignores the traditional belief among some Native women that health is a balance between mind, body, and spirit. Yet Native identity itself has often contributed to disharmony, as many Native women struggle to reconcile their identity as "Native" in the face of conflicting messages from the dominant culture that label them as different or as "Other" (Barrios & Egan, 2002). This struggle affects how they view themselves in relation to others, including health-care providers, the majority of whom belong to the dominant culture.

In the present study I also address constructions of "identity" in a Native context. According to Mihesuah (2003), "there was and is no such thing as a monolithic, essential Indigenous woman. Nor has there ever been a unitary 'worldview' among tribes or, especially after contact and

interaction with non-Natives, even among members of the same group” (p. xv). Identity is complex; it is fluid rather than static. Individuals shape and are shaped by internal and external forces, reconfiguring their identity over time. For some, the focus of this reconfiguration is issues of personal renegotiation, while for others it is the power of the dominant society to define “Native” (Squire, 1996). For the women in the present study, this fluid construction of identity was the cornerstone for understanding the relationship between health-care decision-making and identity.

I have chosen to use the descriptors “American Indian” and “Native.” “American Indian” is the term currently used by many tribal groups in the United States to describe themselves. It is also the term used by the US Census Bureau when presenting health indicators and statistical data (Roubideaux, 2002). The term “Native” is more complex. According to Mihesuah (2003):

There is no voice among Natives because there is no such thing as a culturally and racially monolithic Native woman. The label “Third World Women” is a large umbrella under which another umbrella, “Natives,” may fit, but underneath that umbrella are each of the three hundred or so modern U.S. tribes and, still further under, each female member of those tribes. Thousands more umbrellas are needed to account for the tribal and individual socio-cultural changes that occur over time. (p. 7)

As it is not possible for me to present all of those “umbrellas,” I have chosen the “Native” one. While acknowledging that there may be issues with this choice, I believe this umbrella term reflects the diversity of women in the study, as well as those in the research reviewed, and is acceptable to American Indian scholars such as Squire (1996) and Mihesuah.

Extending the analysis beyond the physical, to the relationship between Native identity and health-care decision-making, may help us to understand the complexities inherent in Native identity; for example, Native identity may be contributing to both the resiliency and the despair that some Native women experience.

The impact of identity on health-care decision-making will be the focus of this paper. Following a review of the literature, the findings of a study with American Indian women from Vermont will provide the basis for an examination of the complexities surrounding identity and health-care decision-making. Concluding remarks will address nurses’ role in maintaining health inequities and some strategies for eliminating health inequities in Native populations.

Literature Review

It is clear from the literature that many different terms are used to describe study populations. The choice of language varies with each study — from specifically naming the tribe to which the participants belong, to using government-determined labels, to applying broad terms that encompass many different groups of people. These variations remind us that language does more than simply convey information; it plays a significant role in constructing meaning. This is especially relevant when the focus is identity, when how one is named has a tremendous impact on how one sees oneself and is seen by others. As Kirkham and colleagues (2002) state, “Language itself is not a neutral vessel of communication but a social power and an active site of contestation through which meanings are made and remade” (p. 229).

For consistency and clarity, I have chosen to retain the terminology used by each study to describe its population. I remind the reader, however, that, throughout the world, members of the dominant society have lost, changed, imposed, or simply ignored the names of Native peoples. According to Allen (1986), namelessness is significant: “An Indian without a name is powerless indeed” (p. 142).

Although I located no research specifically examining the relationship between identity and health-care decision-making, I did identify research that supports the goals of the present study. For example, Bartlett (2003) focused on the impact of colonization on Aboriginal groups in Canada. She suggests that the destructive influence of colonization, such as sociopolitical identity conflict between Aboriginal groups, inhibits the collective movement of Aboriginal peoples towards the attainment of a more secure future in Canada. Bartlett argues that a careful examination of cultural understandings, and how culture has been affected by sustained contact between groups, is needed in order to design appropriate, culturally grounded approaches to improving the health and well-being of Aboriginal peoples.

Identity has also been shown to be contextual, contingent, and shifting over time. For example, Long and Nelson (1999) focused on resiliency among Native Americans. The purpose of their study was to establish the reliability, validity, and utility of the Ethnic, Culture, and Religion/Spirituality Questionnaire for Native American culture. Their focus was on measuring American Indian family resiliency based on a relational worldview. In this secondary data analysis examining cultural resiliency, they compared non-Native and Native Americans (cross-group), as well as urban and rural Native Americans (within-group). Three factors were measured to assess cultural resiliency: religious identification and community activities, language, and ethnicity/cultural identity. The authors found

differences between individual tribes, particularly rural compared to urban dwellers, suggesting that residence affects traditions, culture, and language. Although Long and Nelson reason that these differences indicate that rural dwellers were in the process of seeking tribal identity and were therefore more conscious of traditions, they assume that similar scores for reservation-based and urban Native Americans indicate that they were more unconsciously accepting of traditions and culture as a way of life. Considering the variations between reservation dwellers and urban dwellers, especially in terms of tribal identity, it seems premature to categorize these distinct groups in the same manner.

Several studies identified the theme of reconnecting or reclaiming. For example, Barrios and Egan (2002) explored the experiences of Native American women, living in the majority culture, of being Native and of being Native women. The participants reported that they experienced a “process of reconnecting” with their Native heritage (p. 223) in adulthood, and thus were able to construct a sense of self as Native. As adults, they sought modes of expression and learning that would bring them closer to their Native heritage and empower them as women. The authors did not address the impact of this reconnecting process on health or health-care decision-making.

Napholz (2000), in her study with urban American Indian working women, describes a similar process, labelled “reclaiming the self,” in which women developed a sense of self in concert with family and the American Indian community (p. 259). The development of self was enhanced through retraditionalization efforts that fostered a positive American Indian identity. Through retraditionalization, the participants “obtained emotional support and strength to help cope with multiple-role commitments” (p. 264). For these women, positive self-image and psychological well-being were reinforced and supported by involvement in traditionally based practices. They achieved balance by reclaiming their American Indian identity.

Valuing Native women as cultural bearers was a theme in several studies. For example, Browne and Fiske (2001) examined encounters between First Nations women from northwestern Canada and mainstream health-care providers. Affirming encounters were perceived as those in which health-care providers showed respect for the participants as women with a unique cultural heritage. The authors report that providers who validated women’s self-identity and cultural pride “signaled a willingness to listen to the patient and to understand her health within the social and cultural dimensions that she defined as most important to her” (p. 141). According to Browne and Fiske, these Native women felt validated by having the expertise and traditional healing knowledge of women elders recognized.

In contrast to these experiences of reconnection and validation, in Shaver's (1997) study with Native American women elders in Oklahoma, the participants reported conflict between their Native American perspectives and mainstream social perspectives. These women recounted family stories that revealed "diminishing respect for women elders from one generation to the next" (p. 165) as traditional roles changed and families lost their native culture. Shaver concludes that society, and the Indian Health Service system in particular, does not value women elders and consequently lacks respect for them as individuals and disregards their health needs.

In summary, the literature indicates that Native identity plays an important role in the health and well-being of Native women. It contributes to their physical, psychological, and spiritual health, and helps them to maintain balance in their lives. The present study was designed to contribute to the existing body of research by extending it to the relationship between identity and health, in order to address health-care decision-making.

Procedure

A grounded theory study was conducted in the US state of Vermont with 20 women who identified themselves as American Indian. Strickland (1999) states that grounded theory is "an important research method for advancing understanding and meeting the health needs of American Indian communities, especially women" (p. 524). She concludes that grounded theory is a qualitative method that holds promise for advancing research that is culturally appropriate for Indian people. This paper reports on an influencing condition of the generated theory, Connecting to Nativeness, that strongly impacted women's decisions concerning mammography and other health-care issues.

Approval for the study was received from the sponsoring university and from the peer review committee of the Vermont Breast Cancer Surveillance System (VBCSS), a state-wide database of women who have received a mammogram in Vermont since 1994 (Geller, Worden, Ashley, Oppenheimer, & Weaver, 1996). To ensure anonymity, a numerical coding system was developed, based on the order of enrolment in the study. This system was used throughout the data-collection and analysis processes. The number that appears at the end of each quote is the number that was used in the original transcript for tracking and referral purposes.

Initial recruitment approaches included informal networking and snowball sampling. Cannon, Higginbotham, and Leung (1991) identify these as outreach strategies that, although labour-intensive, are particularly successful in recruiting minority women. They identify personal

contact as a means of assuring minority women that “neither they nor others would be exploited by the research process or its products” (p. 113). Later recruitment approaches for reaching breast cancer survivors included use of the VBCSS. Neither federal nor state recognition of tribal affiliation was required for participation in the study.

I must state at the outset that I am not American Indian. Although I initially thought this would inhibit my recruitment and data-collection efforts, I learned that my personal outreach efforts prior to beginning the study, and my decision not to work through official Indian channels, enhanced my connections with the many Native groups in the state. When questioned by participants regarding my interest in the health of Native women, I explained that I am Mexican American and very concerned about the health of underserved populations, women of colour in particular. Although I believe my identity as “Other” (Canales, 2000) provided a certain level of trust, I recognize that participants decide what to share and that all interviews are only partial “givings” of the self (Ellsworth, 1989).

A semi-structured interview guide was developed for the study. It included broad, open-ended questions intended to explore participants’ perspectives of health in general and breast health and mammography in particular. During the 1-year study period, I conducted 20 face-to-face interviews with women in their homes, at their work sites, and in Native community spaces. The interviews ranged from 45 minutes to 1 hour and 45 minutes in length. In addition to the interview, the women completed a brief demographic form. They were compensated for their time with a \$25 cheque and a gift bag containing breast health information, including literature specific to American Indian women.

Data were analyzed using the constant comparative method and line-by-line dimensional analysis (Caron & Bowers, 2000; Strauss, 1987). A line-by-line analysis of interview transcripts allows the researcher to discover and describe the dimensions of the phenomenon as conceptualized by the participants (Bowers, 1988). The software program *NVivo* (Qualitative Sources Research, 1999) was used to systematically organize and manage individual interview data; it enabled analytic comparison of the interviews and facilitated examination of the emerging themes and relationships between the influencing factors.

The participants reported various tribal affiliations, including Abenaki, Mohawk, Sioux, and Cheyenne. More than half (12/20) described themselves as “a mixture” or of “mixed race,” usually European and American Indian ancestry, the remainder (8/20) identifying themselves as American Indian only. The women’s ages ranged from 39 to 75 with a mean age of 53. Six of the 20 women were breast-cancer survivors. Several women reported having a limited income that affected their ability to access

medical care. Educational level ranged from completion of 5th grade to master's degree. The majority of women resided in rural areas. In summary, the sample represented a diverse group of women in terms of Native ancestry, health status, economic status, educational level, and geographic residence.

Results

In Vermont, Native women often live in isolation from other American Indians. The state and federal governments do not recognize the Native tribe that is predominant in the state, the Abenaki. Consequently there are no reservations, designated lands, or defined geographic areas for American Indians, and women who identify as American Indian may or may not have local connections to other Native people. This isolation distinguished the participants from Native peoples residing on government reservations or reserves.

This isolation, combined with a history of eugenics in the state of Vermont (Gallagher, 1999), often negatively influenced the women's ability to maintain connections with tribal family members and traditions. The Eugenics Survey, a study led by Dr. Henry Perkins, was an attempt to find and isolate village- and farm-dwelling families perceived to have "bad" genetic traits (Wiseman, 2001, p. 147). American Indians, particularly the Abenaki, were targets of this ethnic intolerance. In order to survive, many Native people renounced their Indian ancestry or "passed into other, less despised segments of society" (Wiseman, p. 149). This disconnection led to a lack of knowledge of family history, traditions, and tribal ancestry among many of the study participants and played an important role in the efforts of some to reconnect with their Native culture and re-establish their Indian identity.

Once again the issue of language must be addressed. During the interviews, the women used a variety of words to describe themselves, their American Indian friends, and their community. Some used the word "Indian," others "Abenaki," still others "Native" or "Native American." This range reflects the various ways in which the women viewed their Native heritage and their various constructions of "Indian." The terms "American Indian" and "Native" will be used interchangeably throughout this analysis. Although some women referred to their American Indian friends simply as "community members," this reference did not apply to all of the women interviewed. It is a confusing term when used without sufficient context. During the interviews I often used the term "Native" to clarify the meaning of community. The women responded to this term and never once reacted negatively to it. I therefore chose to

use this word, often to distinguish American Indian friends and community from the community at large.

Finally, the issue of rigour is especially relevant when data are being collected from members of a marginalized population. Throughout the research, the analysis was evaluated using interpretive evaluation criteria (Guba & Lincoln, 1989). The parallel or foundational criteria used to judge the adequacy of the study included credibility, transferability, dependability, and confirmability (Guba & Lincoln). For example, credibility was assured through debriefing between the author and a research mentor during monthly meetings throughout the study; monitoring the researcher's developing theory through regular memos; and checking the results with the participants, in both written and verbal formats. Transferability was established through the thick description and richness of the generated theory. Dependability and confirmability were pursued through the use of a numbering system to track quotes incorporated into the analysis; the coding, management, and storage of data using *NVivo* software; and detailed memos of the processes for developing the analysis, as well as the emerging analysis itself. All criteria were met through presentation of the research findings in venues where the participants and other American Indian women were present and where the results were confirmed.

Connecting to Nativeness

[Native culture] reinforces everything I've thought of for years, because I see the full connection between the physical, the mental, the spiritual — to have complete health. Before, it was... just, this is your physical health, and now it all balances. [04]

The women described various degrees of connection to their Native culture and traditions. Connecting to Nativeness had a greater influence on health-care decision-making among women who identified very strongly with their American Indian ancestry. Although all the women identified themselves as American Indian, some felt the connection more than others. Therefore the participants experienced various degrees of Connecting to Nativeness. On this score, the women ranged from those who did not perceive themselves as Native in terms of their interactions with others and their beliefs about and participation in traditional practices:

I guess because I don't feel culturally connected... I didn't feel that I needed to be exploring, you know, those Native Americans... [03]

to those who were becoming reacquainted with their tribal heritage:

I didn't become interested in it in an organized way more or less until they [the children] were older...in college and...out of the household. [07]

to those who became immersed in cultural practices after Connecting to Nativeness through family members, Native leaders, courses, or self-exploration:

The grown-up calls you. It's more spiritual than anything else. You feel...for me, I felt I came home when I saw the powwow and started to feel the vibrational healing and they just invited me in. [04]

It's interesting, because she [mother] never ever said anything to me...growing up. But I shared a few things with my cousin, who was up there at the time, and she seemed to be very interested. And she said, "I understand what you're saying." I wish we'd had this connection years and years ago. [12]

to those who had been raised Native and had always thought of themselves as such:

My grandmother taught us a lot of things. She used to drink a lot of chamomile tea and I can remember her telling us different things for different ailments and stuff. [09]

My dad used to talk about how the last Native American sweat that was done in our area...in the early Thirties. He was probably...12 years old. And he said then they stopped. A lot of people went in deep hiding. [11]

The degree of Connecting to Nativeness influenced the women's health-care decision-making in terms of their beliefs about health, their ability to treat themselves and their families, and their desire to integrate traditional healing practices into their lives. Consequently, their health-care decisions were often influenced by their degree of Connecting to Nativeness and the extent to which they integrated Native traditions and beliefs into their personal philosophy of health and healing. The women were Connecting to Nativeness both individually, by independently exploring their Native heritage, and collectively, by participating in Native events such as women's circles and powwows and assuming leadership roles in their local Native community. These processes of connecting will be described below.

Individually Connecting to Nativeness. For some women, particularly those with strong family ties to their Native culture, Connecting to Nativeness was simply part of who they were as women. These women had been raised in traditional ways, with Native beliefs and practices part of everyday life. For them, Connecting to Nativeness was not a choice or

a decision they had come to as adults; it was part of their being from birth:

I have trouble in my regular life, hiding that I'm not a real person, that I'm not a real white person. I've had that problem all my life... If you're raised by the people I was raised by...it's hard to fit in and be a white person. [16]

Some of the women who had been raised as American Indians strengthened their Connecting to Nativeness as they aged, deciding that their overall health could be improved through integration of and participation in Native health practices:

Instead of going on blood pressure medicine I'll go have a sweat done, which will take a lot of the anxiety...and then I'll go to the doctor and she'll check my blood pressure and I'm fine. [11]

Some used traditional health practices in an effort to counter the perceived negative effects of conventional treatments:

With X rays I just feel it's just too much...it doesn't feel natural to go through it. They'd [mammograms would] be putting more chemicals into my body and...I'm trying to get those chemicals out from all the years of going through X rays. It's just scary. [11]

One participant who had been raised traditionally moved away from Native practices when she became part of “corporate America”:

I'm a little ragged on the spirit side right now because I spent the last 10 or so years making money. I used to be more of a drifter...jobs wherever...hung out in more of a Native American community, you know, drumming and things... I moved to Seattle. I lost contact with all my older friends and I started just working. Working, working, working. I've just been working for corporate America and not doing anything like that any more. [16]

Yet her connections to and interest in her Native heritage never waned:

Never less [important], just less time for it when you're...paying a mortgage and you just have less energy. [16]

Prior to her breast cancer diagnosis, however, she reconnected to her Nativeness by making a labyrinth, a traditional walking path:

I began learning how to draw these labyrinths on paper. It's very soothing. And so I said, by damn I'm going to make a labyrinth in that yard, in that field. I made the ancient type. And I made the labyrinth, I began walking it, and 20 days later I felt the lump and then a week or so later I

found out I had cancer. And labyrinths are traditionally used for cancer walking. So I began walking it all the time until it snowed...that was my entry back into doing that. [16]

These women identified additional options for health and healing as their connections to their Native heritage strengthened as they grew older.

In contrast, some women had been raised traditionally but, as they grew older, decided that conventional health care was more appropriate:

You take care of your body. Your number one priority is to take care of your body. And if that means having a mammogram to be one step ahead, then that's what you do. [09]

Speaking for myself, I didn't want to live like everybody else does. ...I want to get help if I need it. [08]

The above participant wanted to live differently from her parents and women of previous generations. She described other Native women as “more stubborn than I am and try to doctor on their own,” in terms of health care. In contrast, she wanted to be able to access conventional health care if need be. For some participants, therefore, Connecting to Nateness had less influence, in terms of health-care decision-making, as they grew older. These women believed it was important they have access to health care and not necessarily mimic the behaviour of previous generations of women, who did not avail themselves of technological advances.

Other women, however, had been raised within Euro-American society yet chose to learn about and become more involved in their Native culture as adults. They believed that their Native heritage had been purposefully hidden from them, although usually they did not know why or could not explain their family's behaviour. For these women, Connecting to Nateness was a more recent process:

So as far as being out, I mean, we always knew it. But as far as really being vocal, it wasn't until probably '91, '92, and my cousin...always was very vocal about being Native and travelled out west and that kind of thing.... So we just kind of got started and then we started a women's group of Abenaki women or Indian women. [06]

He [son] got interested...because he knows we're Native too, but...he's not sure of what. I'm not sure of what... He was into it probably about 4 or 5 years, even 6 years, before I even got into it. I've probably been into it for about 6 years. [14]

One participant described her increased interest and participation in traditional practices during the preceding 8 years as “reacquainting” [07].

These women engaged in a process by which they came to understand and see themselves as Native and incorporated, to varying degrees, this Native identity into their personhood:

It had been, about 10 years ago, a really intense period of being in touch with my roots, where I spent a lot of time in the woods...a lot of time. ...that's what my focus was for almost a year. [02]

...that started with a college professor I had who was doing a Native American Histories and Cultures class, an anthropology course, and she introduced me to it all. [04]

I don't know if my cultural beliefs itself affect it [health behaviour]. But the way that my culture, the way I live, affects it. I'm very much into the herbology section of my culture. [05]

This participant, who had been exploring her Nativeness for 6 years, described her culture in “sections,” which suggests that her Native culture was not yet all-encompassing but affected only certain aspects of her life. For her, Native culture could be applied or tapped into. At this point in her evolution as Native, integrating herbal plants was the part of her culture that directly affected her health-care decisions. This woman's experience illustrates the fluid nature of identity.

For another participant, a nurse, her increased acceptance of her own Nativeness affected her relationships with her patients:

...it's just an awareness...that their cultures are quite a bit different, you know, than, say, the person in the next bed or the next room...To see their medicine man come in or [their] family remain with them...is something that I now...have a tendency to just accept and realize it's very much a private culture. So it's just being more familiar with some of the cultures and a little more understanding of them. [07]

It is apparent from this comment that the participant was not connecting to her own Nativeness to the same degree that some of her patients were connecting to theirs. She accepted “their cultures” instead of perceiving herself as part of those cultures. This comment highlights the extent to which Connecting to Nativeness was an ongoing process for some of the women.

Another nurse participant did not perceive herself as Native and consequently was not Connecting to Nativeness at all. Although her cultural heritage did not affect her personal health-care decisions, she was willing to assist her family members and patients connect to their Nativeness:

When my mother-in-law was living with us and had lymphoma and was definitely terminal, she wished she had some essiac tea that she wanted to

take. We'd already checked and there was no contraindication in how it would affect her care. It was important to her, so I was willing to do that. And maybe...some of my cultural aspects made me more willing to follow that. ...But I don't think it [cultural heritage] affects my own personal care in any way. [03]

However, although she was not Connecting to Nativeness at the time of the interview, the possibility for future connecting existed:

It's just something to look at and puzzle about. And I say, well, maybe some day I'll investigate that. [03]

The above participant agreed to participate in the study as a spokesperson for the financial constraints affecting mammography use among local Native and non-Native women. Consequently, her health-care decisions were influenced more by economics than by any connection to her Native culture.

The women's degree of Connecting to Nativeness affected not only their health-care decisions, but also the quality of the care they and their family members received and their interactions with health-care providers:

When they can't find the problem they...want to send you to mental health because it's all in your head type thing. And that's the way they are out there... What's the sense of going? They're not going to help you. [08]

If you treat them like a dummy... "You can't heal yourself with all your own medicine." Well, that's not true, you know. They've been doing it for centuries. Treat them with some respect. Try to add their agenda into yours. [09]

Within a 7-year span I've just watched [Native] people be treated like dirt. I wanted to make a difference for people, and I think that's why I got so involved in health-care stuff, because I've seen them [health-care providers] tell extended family...you need mental health... You walk out of there and you take them to [a different hospital]...and then they're admitted for 9 days because they have a blood clot, poisoning their body. And you just sit back and wonder why nobody even noticed this. [11]

Consequently, for some women, their identity as Native marked them as Other in the minds of some local health-care providers. The racism they experienced in these encounters ultimately discouraged them from using conventional health services. The majority of participants did not have visible features that would readily identify them as American Indian. However, while the ability to move between cultures without having their Nativeness recognized afforded a degree of protection against

racism, some of the participants were identified in the community as Native because of their families or because of their Native practices:

By the time we got in there to see the doctor, I ended up literally crying because I asked him if we had to take this stuff, this ridicule out there, sitting in the waiting room — people making fun of you behind the desk. It was comments and I didn't like it, and I felt we didn't have to be treated that way. We're just as human as anybody else even though we're different... But we're Native American so... Oh yeah, we've felt that way a good many times...you get to the point where you hesitate going there. [08]

These racist encounters influenced participants' personal health-care decisions and ultimately their view of the health-care system:

I guess we're kind of hesitant because we had a lot of bad experience [at the] hospital here. Well, one night my husband was really in a lot of pain so I said, "Come on, I'll take you to outpatients." So I took him. We brought him in. All they did was ask him if he — "Do you take drugs? Do you got needle tracks?" Never got to the issue that was bothering him. Sent him home. And I know my husband. He walked into the house, never took his coat off, nothing. Stopped in the chair. And I said a bad word and I said, "We're going to [a different ER]." Well, if I hadn't took him [to the different ER] that night he would have died because his bladder would have erupted. [08]

I guess trust is the biggie for me. And I still don't really fully trust them. I mean, it's hard to trust people who have turned against you. So, being Native, yeah, I think it plays a big role when people walk into [the local hospital]. [11]

Consequently, those women who were known as American Indian sometimes had to base their decisions on whether to seek conventional care on the seriousness of the health condition as well as their ability to withstand the racist attitudes they might encounter.

Several participants said that racism compounded their Connecting to Nativeness efforts and heightened their feelings of mistrust:

Because of racism you might be doing this kind of religious practice [sweat lodge] where you live, at home, and somebody's going to call the fire department on you because you have a fire without a permit, and they're going to find a way to harass you. Or some Christian person is going to say that you're worshipping the devil and you should be, like, shot. Unless of course you're a white person who is stealing the ceremony, and then everything is okay. So it's really hard. You feel very vulnerable and you don't know who to trust. [01]

People get ostracized terrible for admitting they're Native around here — by the rest of the town. They've been trying to get me out of my home for 10 years now. They've stolen trees, destroyed property, my mailbox has disappeared... I've had my...tepee...slashed. [04]

I could pass very easily as being Scotch or whatever. So for me it [racism] wasn't ever a problem until just last year when I went to a town planning board meeting. [06]

The above participant's Connecting to Nativeness efforts had not been an object of racism in the past. Recently, however, despite her physical invisibility as American Indian, her very visibly Native actions had provoked racist responses. Racism increased as an issue for the women as they became more connected to their Nativeness. This consequence of Nativeness had not been anticipated by those who had not been perceived as Indian within their community.

Several women discussed the lingering influence of the Vermont eugenics movement on Native perceptions of health, health-care decisions, and participation in research:

Some Native women...believe that this [mammography] is a way to actually try and kill women. That it's the government doing this, and if, for example, some white researcher wants to ask you a bunch of questions or to encourage you to get a mammogram, don't do it, because it's the government. Or it's like eugenics. Or it's like what they did to the Alaskan Natives who have gotten multigenerational thyroid disease from being used as guinea pigs [in] radiation studies. [01]

Especially [with] my generation and the older generation, there was so much with eugenics program and all those things that went on that they still have that mistrust of government, mistrust of doctors, mistrust because of the sterilization... They know it, they keep it within their families, but want to stay in the background. And they'll do things and they'll have their own gatherings or they'll come to a gathering but if you said to them, "Are you Abenaki?" they'd say, "No." [06]

For many Native people, the past continues to influence the present and cannot be dismissed or ignored. Connecting to Nativeness has real consequences for Native people in the racialized world of health-care delivery.

For many participants Connecting to Nativeness was an individual process that they engaged in over time and to varying degrees. For some, health-care decisions were limited to their individual Connecting to Nativeness. For others, however, health-care decisions were influenced by their collectively Connecting to Nativeness efforts.

Collectively Connecting to Nativeness. Although collectively Connecting to Nativeness was not necessary for all participants, the majority of women described the importance of collectivity in their lives and their efforts to connect with Native groups:

You have to have that [community]. It's very, very, very hard to live totally traditionally in terms of your health care... Very hard. You can't do it independently. It's interdependent. [01]

...women's groups that I'm in that are Native American groups. They're a group of women that meet...stay in touch with and reacquaint ourselves with some of the traditions that have become lost along the way. [07]

I have some wonderful sisters and brothers and elders in this area, and...being back here has been wonderful as far as being able to be freer...to feel freer to be okay with who I am. ...A reconnection with [a Native friend]...too, being invited to Thanksgiving gatherings, and it's just great. [12]

Collectively connecting with a Native community while individually connecting with their Nativeness was important for these participants. This interconnection between individually and collectively Connecting to Nativeness was especially relevant for women who had decided to integrate more traditional practices into their health regimen:

I know a person who went into a sweat lodge with diagnosed kidney stones, came out, went to the doctor a few days later and they were all gone. I've seen this kind of thing happen. But you can't just do those things on your own. It's the power of a group of people who get together, who all understand what's going on. They have good hearts and good minds. [01]

And of course we have contact with other Native people from Canada. There's a man and a lady that come and they do sweats and everything every year. She teaches me a lot of things about different herbs for different ailments. So I do know quite a bit. [09]

I've just gained so much. Connection. What you can learn from others and what I learn I hopefully am passing on to those working in the school systems. [12]

Some women who were collectively connecting with Native friends and communities sought their opinions when trying to make health-care decisions:

Mainly what I need to hear from...community people is that they've been there and they feel very comfortable. And their comments usually are,

they're just, like, community people. And then I might take the chance. ...I really value their opinions. [10]

It was important for these Native women to learn from family members or Native friends about health-care providers who were perceived as trustworthy before seeking out their services.

Some women found it difficult to connect to Native individuals and groups, due either to rural isolation or to fear because of historical practices that dispersed Native people in the area:

Unfortunately I don't know a lot of people because I really am pretty isolated. [02]

There's a lot involved in exploring your culture, and it still brings up some negative thoughts by some elderly family members. People just don't admit that they have any Native American [blood], because it wasn't that many years ago that if you were Native American you were looked down on, so...family members...did not pass on that there was any Native American in you. I remember talking with my great-grandfather and he was starting to bring up some of the old family past and then my great-grandmother suppressed him. So I don't know a lot about my cultural past. Because they were afraid, they didn't share it. [03]

...it's not like you're on a reservation where they're just all there... It isn't that way here. Everybody's dispersed and half of them won't admit to their heritage. It's not really safe. [04]

In most Abenaki families and communities there's...a whole community behind what is on the surface level. So there's usually a representative here or there, in most enclaves, that are the up-front people. And then there are the kind of in-between that are a little bit up-front. ...and then there are the ones that remain hidden and completely unknown and want to be. [06]

Because of the dispersal of the New England Abenaki and members of other Native tribes, many participants had a desire to collectively connect with a Native community, to develop networks of Native friends across the continent:

So that helps to take away the isolation. If I didn't have the Internet, I don't know... I can hear from other people and read what they say. It really helps to sort things out. [01]

They're not just...here, just in Vermont. We've got friends in Maine. We've got friends in Florida. We've got friends in New York. There's people that come from the Rosebud Reservation. [05]

We have people that we consider part of the community from Sherbrooke [in Quebec], from Massachusetts, from New Jersey, from Maine, New York State. A lot of them we've met have come out for things...we've met on the powwow circuit. And a lot of them we've never met but that just write, through letters and e-mail. [06]

These comments reflect the nature of the communities that participants had developed. For some participants, collectively Connecting to Nativeness occurred at different levels. They connected to Native friends in Vermont and expanded their Native community to other states and provinces through the powwow circuit, newsletters, and the Internet.

Several participants who had no local Native community perceived that if they lived on or near a reservation they would be able to strengthen their connections to their Native heritage:

I can imagine if I had gone, if we go west, it will be totally mind-boggling... We wanted to move to South Dakota, out to Pine Ridge, and live close to the reservation. So that would be helpful. [05]

I've often wanted to go to a reservation and ask some women there... "Okay, look at me. I'm part Mohawk. Could you just talk to me about this thing that I felt I had to make, this mask, and why? What should I do?" But maybe they don't know. [16]

One woman believed that closer ties to a Native group would affect her health-care decisions:

I wouldn't need allopathic medicine, I don't think, if I was living in a group situation where I was surrounded...like on a reservation. They have so many elders who do this work. I could go to that person, get my medicine from them. Even if I pay for it, that's not a problem. It's the right kind of medicine. [01]

Some women believed that living near a recognized tribal group would help them in their individual Connecting to Nativeness efforts and strengthen their Indian identity, which, in turn, would increase their health-care options.

Some women with strong connections to a Native community believed that conventional health care was not always necessary:

Well, some really, really traditional people would say that you don't need to do any of these things. I have seen incredibly healthy people...live into a long age and never have any screenings and be totally healthy. ...it's because...they're involved enough that they can see what's going on in their own bodies — sometimes they can see what's going on in other people's bodies — and they don't need technology. [01]

This participant had connected with Native elders and made them a part of her life. Although she stated that she did not possess the abilities she witnessed, the longevity and overall good health of the elders were, for her, evidence that health was not necessarily dependent on conventional health care.

Discussion

Ethnic identity and self-identification are inherently linked. How one defines oneself in relation to one's ethnic group influences how, or if, one identifies ethnically. According to Phinney (1992), "Individuals who use a given ethnic label may vary widely in their sense of belonging to their group, their attitudes toward the group, their ethnic behaviors, and their understanding of the meaning of their ethnicity" (p. 159). For the participants in the present study, clearly, variations in self-identification as "Indian" existed and changed over time. This finding sits in contrast to the results of an ethnic-identity study with high-school and college students, which found that ethnic identity "consolidates with age" and stabilizes early in adulthood (Phinney). Considering that, for many of the women in the present study, the process of connecting with one's ethnic group persisted well into adulthood, nurse researchers must be cognizant of the fact that identity is not a static state, but evolves as attitudes about self and others develop and evolve. Nurses must consider this fluidity when planning research studies with Native women.

Although this study focused on the influence of Native self-identification on health decisions, it is important for nurse researchers to acknowledge that for many Native people identity as "Indian" is externally imposed and officially dictated. In the United States, for example, the government imposed the use of blood quantum — the percentage of Native blood by biological inheritance — as a criterion for entitlement to federal benefits (Barrios & Egan, 2002). The US government still uses blood measurements to "officially mark" Native peoples today (Strong & VanWinkle, 1996). In Canada, the 1876 *Indian Act* continues to "regulate who is entitled to be 'Indian' and controls First Nations peoples' lives to a significant degree" (Krosenbrink-Gelissen, 1995, p. 198). Consequently, identification as "Indian" influences much more than health-care decisions; it can mean the difference between belonging and not belonging to one's tribe.

Distinctions between and within tribal groups based on government tribal designations also influence identity. For example, in the United States self-identification can change when "a formerly 'unrecognized' tribe becomes federally recognized by Congress, when tribal enrollment ordinances change, or when tribal enrollment ordinances change regard-

ing paternal versus maternal lineage” (Burhansstipanov & Satter, 2000, p. 1722). These government and tribal definitions of “Indian” have an impact on self-identity as well as access to health-care services, including eligibility for Indian Health Service care, federal funding for housing, and casino profits (Metz, 2003). When developing studies, planning recruitment strategies, and analyzing data, nurse researchers must be cognizant of the historical relationship between Native identity and government recognition, the impact of official identity determinations on eligibility for federal resources, including health-care services, and the tensions that exist between Native peoples who are officially recognized and those who are not.

Similar to the findings of Barrios and Egan (2002), in this study *Connecting to Nativeness* was an empowering experience for many of the participants. Although many of the women did not have Native adult female role models, they constructed their own sense of Native identity through self-education, formal education, and connections with elders or medicine people within their Native network. Acknowledging Native identity as a source of strength and resiliency rather than as a barrier to health-care services can be the first step in developing respectful interventions. As Blaeser (1997) contends, “If we truly understand connection and interdependence we will develop respect for other beings” (p. 561).

Nurses who view *Connecting to Nativeness* as a source of empowerment for Native women can incorporate this process into their efforts to build trusting relationships with their clients. Nurses who recognize Native women’s internal sources of strength, acknowledge the many ways in which they maintain health, including their traditional practices, and provide care in a non-judgemental, respectful manner will begin to gain the trust so vital to the nurse-client relationship. Concurrently, nurses can begin their own reflective journey, examining the multiple positions they occupy as members of the dominant culture (in many cases) and dominant health-care system, the power inherent within these positions, and the impact of this power on the nurse-client relationship. This form of self-reflection challenges nurses to critique their own worldviews as well as their self-identities (Canales, 1998). In this way, individual racism can be addressed and trusting relationships fostered.

Although identification as Native was a source of strength for many women in the study, it was also a source of mistrust. It is imperative that nurses caring for Native women acknowledge the colonizing practices that forced many American Indians to hide their identity and the subsequent trust issues that developed for Native women connected to or in the process of connecting to their Nativeness. This historical context explains the tensions experienced by some Native women as they decide whether to seek conventional care. Unless nurses acknowledge the fear

and mistrust of Native women, and the historical context of that fear and mistrust, their efforts to develop positive relationships will be thwarted. Browne, Johnson, Bottorff, Grewal, and Hilton (2002) offer several strategies nurses can employ to identify discriminatory practices and build more trusting relationships. These include developing critical consciousness, monitoring the language used to refer to people who are different, and exploring approaches to naming and discussing racism and other forms of discrimination.

Finally, even though Connecting to Nativeness was an empowering process for many of the women, the racism they experienced must be addressed. They found these experiences humiliating, terrifying, and potentially life-threatening. These findings are similar to those reported by Browne and Fiske (2001) in their study with First Nations women in northwestern Canada and by Shaver (1997) in her study with Oklahoma Native American women elders. The health of women who identify with, and are identified by, their Native heritage is further jeopardized by the health-care system. Nurses can no longer “afford ignorance about one of the major factors that contribute to multiple health inequities — racism” (Porter & Barbee, 2004, p. 10). Individual and institutional racism continue to influence access to services and the quality of services received by racial and ethnic populations in the United States (Institute of Medicine, 2002) and Canada (Canadian Institute for Health Information, 2004). “Nurses, in order to actively participate in eliminating disparities, must consider critically the issue of how race and racism within the broader contexts of power relations and social inequality influence the quality of their services” (Porter & Barbee, p. 10). Once nurses have critically analyzed these relationships, they must take active steps to address them.

Conclusion

Examination of the influence of identity on health and health-care decision-making is becoming more important as members of Native groups reclaim their ancestral lands, traditions, language, and identity. According to Bartlett (2003), “since the earliest continuous contact with newcomer Europeans, original peoples have been erroneously identified by externally designated and often misleading names such as Indian, Eskimo, and Half-breed. This has resulted in poor self-image for individuals and groups who have in some cases, in order to survive, gone underground with their identity” (p. 166). Some Native people, however, are seeking to reclaim their identity as Native, constructing a self that enhances their own image and that of their community. Through Connecting to Nativeness, the women in the present study were reclaiming their Native

identity, living the words of Paula Gunn Allen (1986): “We daily demonstrate that we have no intention of disappearing, of being silent, or of quietly acquiescing in our extinction” (p. 193).

Eliminating health inequities among Native populations will require an understanding of the social, political, historical, and economic issues that affect these groups as well as a willingness to examine nursing’s role in perpetuating the inequities. Nurses can play a greater role in addressing health inequities by working in tandem with Native communities to design research studies and develop interventions that are grounded in the needs of the community and that are reflective of the diverse identities of Native peoples. Flaskerud and colleagues (2002) report that these types of studies “also provide a valuable resource to communities and their members by sharing power with them and involving them in knowledge and skills that are translatable into action” (p. 83).

Finally, the present findings remind us that if we are to eliminate health inequities we must confront the institutional racism that persists within the health-care system and beyond. Nurse researchers are challenged to extend the analysis from the micro, individual, level to the complex social, economic, historical, and political intersections in which human lives are experienced. As Campbell, Copeland, and Tate (1998) state, “If researchers are to understand what people tell them about their lives, their troubles, or their health care experiences, then the inquiry must include not just people’s stories but how powerful outside forces shape their experiences” (p. 96). This approach is especially salient for Native peoples whose very existence has been threatened by “outside forces,” including the health-care system.

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