

## **Des récits de vie autochtones constituant des récits sur la santé et la résistance : une analyse narrative dialogique**

**Bodil Hansen Blix, Torunn Hamran, Hans Ketil Normann**

Dans le passé, les Sami ont été exposés à d'importants processus d'assimilation. La présente étude visait à explorer les expériences de personnes âgées sami en matière de santé. Au total, 19 aînés sami vivant en Norvège ont été interviewés. Le présent article constitue une analyse narrative dialogique des récits de vie de trois femmes du peuple sami. Les histoires de vie sont perçues comme des récits sur la santé et la résistance. La théorie postcoloniale procure un cadre pour comprendre l'incidence des facteurs historiques et socio-économiques sur la vie et la santé de ce peuple. Les récits de résistance montrent que les gens ne sont pas des victimes passives de l'héritage du colonialisme. La résistance n'est pas un état passif, mais un processus actif, tout comme la santé. La résistance constitue une ressource dont les services de santé devraient être conscients, tant au niveau systémique, par exemple le partenariat avec les aînés autochtones dans la planification et l'établissement des services, que dans les relations individuelles entre les patients et les fournisseurs de soins de santé.

Mots clés : Sami, santé, résistance, théorie postcoloniale, Norvège

# **Indigenous Life Stories as Narratives of Health and Resistance: A Dialogical Narrative Analysis**

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The Sami people have historically been exposed to severe assimilation processes. The objective of this study was to explore elderly Samis' experiences of health. A total of 19 elderly Sami individuals in Norway were interviewed. This article is a dialogical narrative analysis of the life stories of 3 Sami women. The life stories are perceived as narratives of health and resistance. Postcolonial theory provides a framework for understanding the impact of historical and socio-economic factors in people's lives and health. Narratives of resistance demonstrate that people are not passive victims of the legacy of colonialism. Resistance is not a passive state but an active process, as is health. Resistance is a resource that should be appreciated by health services, both at a systemic level — for example, through partnership with Indigenous elderly in the planning and shaping of services — and in individual encounters between patients and health-care providers.

Keywords Indigenous people, Sami, health, resistance, postcolonial theory, narrative inquiry, Norway

## **Introduction**

While conducting research in the field of Indigenous people and health, one frequently encounters a distinct tendency in the research and theoretical literature: the view that “cultural competence” is of great significance in the interactions between health-care providers and “minority patients.” This view is described as an emerging “mantra of contemporary nursing practice” (Dreher & MacNaughton, 2002, p. 181). Over the last decades, matters of culture, health, and health care have been discussed extensively (cf. Vandenberg, 2010). The focus on cultural competence is also reflected in various government documents (e.g., Joint Commission on Hospital Accreditation, 2008; Office of Minority Health, 2001; Romanow, 2002) and in the education of health-care providers (Like, 2011; Mancuso, 2011; Office of Minority Health, 2002; Ring, Nyquist, & Mitchell, 2008). In our opinion, the focus on cultural competence is too narrow and has several implications. Culture appears to be perceived as relevant only to people who are different from the majority. Furthermore, the focus on culture might divert attention away from the

broader historical and social contexts that influence people's health and their experiences of health services.

This article is based on a qualitative study of elderly Sami individuals' experiences of aging, health, and illness. Through the presentation and discussion of the life stories of three elderly Sami women, we illuminate how the history of colonization is present in elderly women's lives and impacts their health experiences. The three women, while telling their stories, actively engage with the impact of history on their lives and their health. We argue that an acknowledgement of health as an active engagement with history renders the focus on "cultural competence" in health care too narrow. We begin with a brief description of the Sami and some significant events in their history within the Norwegian national state. This is followed by a review of the research literature on the Sami and their health issues. We next present some central key concepts, including life story, health, postcolonial theory, and narratives of resistance. This is followed by a description of our research method and methodological considerations. Then we present and discuss the life stories of the three Sami women. We argue that understanding health as a condition of subjectivity and as influenced by broader historical and social contexts is essential to gaining a richer understanding of the health of Indigenous people.

### **The Sami**

The Sami are an Indigenous people living in Norway, Sweden, Finland, and Russia. The Sami population is estimated to be between 50,000 and 80,000 (Sámi Instituhtta, 2008). The majority of Sami live in Norway; Statistics Norway (2010) estimates the Sami population of Norway to be 40,000. Historically, the Sami were reindeer herders, small-scale farmers, and fishermen. Today, approximately 10% of the Sami in Norway are engaged in the traditional ways of living (Statistics Norway, 2010). A 2000 report by the Sami Language Council estimated that there are approximately 25,000 Sami-speaking persons in Norway (Ministry of Local Government and Regional Development, 2001).

National governments have made strong efforts to assimilate the Sami into the majority population. In Norway, the process of assimilation, frequently referred to as "Norwegianization," lasted from 1850 to approximately 1980. According to the *Land Act* of 1902, property could be transferred only to Norwegian citizens (i.e., persons able to speak, read, and write Norwegian), and proficiency in the Norwegian language continued to be a criterion for buying or leasing state land until the 1940s. The Sami language was prohibited in Norwegian schools from 1860 to 1959.

Residential schools were important arenas for the Norwegianization of Sami children. The assimilation process was paralleled by individual experiences of stigmatization and discrimination (Minde, 2003).

During the 1950s a growing Sami movement initiated a process of ethnic and cultural revitalization. The establishment of general education based on the Sami language and culture was of great importance to the Sami movement (Eidheim, 1997). The 1970s and 1980s witnessed the “aboriginalization of Sami ethnopolitics and self-understanding” (Eidheim, 1992; Thuen, 1995). The Sami movement established contact with organizations representing Indigenous people in other parts of the world. The raising of Norway’s living standards and general improvements in its welfare and health-care systems during the 1960s and 1970s contributed to the process of ethnic revitalization.

The public assimilation policy culminated in 1980 with “the Alta affair,” whereby the Norwegian state decided to dam the Alta-Kautokeino river despite considerable protest by the Sami, who argued that this would threaten the grazing and calving areas used by the reindeer-herding Sami. The dispute brought national and international attention to the rights of the Sami. The *Sami Act* (Ministry of Government Administration Reform and Church Affairs, 1987), enacted in 1989, enabled the Sami people in Norway to safeguard and develop their language, culture, and way of life. In 1989 a Sami Parliament was established and in 1990 the Norwegian government ratified International Labour Organisation Convention 169 (*Indigenous and Tribal Peoples Convention Concerning Indigenous and Tribal Peoples in Independent Countries*).

In many communities, especially those outside the “Sami core area,” the differences between the Sami and Norwegians are not always obvious (Kramvig, 2005; Olsen, 2010). The coastal Sami population have been greatly affected by assimilation and stigmatization. In coastal areas, fewer people speak the Sami language and many people might not identify with symbolic expressions of a collective Sami cultural heritage. To some people in these areas, “Saminess” is associated with the distant past and of little relevance to their everyday lives (Gaski, 2008; Olsen, 2010). Today’s elderly Sami have lived their lives in this atmosphere of tension between assimilation, revitalization, and ambiguity. Considering the history of assimilation, stigmatization, and discrimination, it is reasonable to assume that the contesting of Sami heritage throughout the course of a lifetime might affect one’s health and well-being in old age. As noted by Minde (2003), “‘the Sami pain’ . . . may have been widespread among those who were in opposition, but probably even more deep-felt and traumatic among those who tried most eagerly to adapt to the assimilation pressure” (p. 141).

## **Literature Review**

Research on health issues among the Sami has been primarily quantitative, and results for the Sami are often compared with those for the majority population. The focus has been on health behaviour (e.g., Spein, 2008; Spein, Sexton, & Kvernmo, 2004), risk for disease (e.g., Hassler, 2005; Nystad et al., 2008), and causes of death (Hassler, Johansson, Sjölander, Grönberg, & Damber, 2005). Research suggests that the Sami do not face the same health-related challenges as Indigenous people in Canada, the United States, Russia, or Greenland (Symon & Wilson, 2009). Many health problems experienced by Indigenous people in the circumpolar region, such as increased risk for diabetes, cardiovascular diseases, infectious diseases, and lung cancer, are not prevalent among the Sami (Hassler, Kvernmo, & Kozlov, 2008). Life expectancy at birth is virtually the same for Sami and non-Sami people, and mortality rates for specific causes are similar (Brustad, Pettersen, Melhus, & Lund, 2009; Hassler et al., 2005). Some researchers (e.g., Gaski, Melhus, Deraas, & Førde, 2011) have attributed the apparent absence of health differences between the Sami and the Norwegian population to the assimilation process, as though health equity were a positive side effect of assimilation. We believe that the causal relations are more complex. In Norway, health services are largely public, which might contribute to higher levels of access to health services than in other countries (Hassler et al., 2008), and living standards are generally high.

Regardless of statistics showing an absence of health differences between the Sami and the majority population, research has identified several health-related challenges. Sami-speaking patients are less satisfied than other patients with the services provided by municipal general practitioners (Nystad, Melhus, & Lund, 2008), and a study of mental health care found that Sami patients were less satisfied with treatment, contact with staff, and treatment alliance than Norwegian patients (Sørli & Nergaard, 2005). Self-reported health is poorer for the Sami than for the Norwegian majority population. This difference is most significant in Sami women living outside the Sami core area (Hansen, Melhus, & Lund, 2010). Sami individuals are more likely to experience discrimination and bullying than the general population in Norway (Hansen, Melhus, Høgmo, & Lund, 2008), and discrimination is closely associated with elevated levels of psychological distress (Hansen & Sørli, 2012). These findings suggest that merely looking at statistics for life expectancy, mortality rates, and disease incidence may be insufficient when grappling with health and health-care issues among Sami people.

With the exception of quantitative measures of self-reported health as “poor,” “not very good,” “good,” and “very good” (Hansen et al.,

2010), we found no studies exploring experiences of health among Sami people. In the present study, we explore the life stories of elderly Sami as sources of insight regarding their perceptions of health. Frank (2006) states, "People understand themselves as selves through the stories they tell and the stories they feel part of. Stories about *health* are, sooner or later, stories about the contemporary shaping of that particular human aspiration, being a *healthy self*" (p. 434; original italics).

### **Life Stories, Health, Postcolonial Theory, and Narratives of Resistance**

In the present study, we defined life stories as the stories people tell about their lives in the context of the qualitative research interview. The plural form, "stories," was used intentionally, to emphasize both that an individual has many life stories and that the stories he or she tells do not necessarily constitute one continuous and coherent *life history*. A dialogical perspective, such as the one chosen for this study, opens the possibility of multiple truths about lives. Riessman (2008) reminds us that "we revise and edit the remembered past to square with our identities in the present" and that "stories must always be considered in context, for storytelling occurs at a historical moment with its circulating discourses and power relations" (p. 8). In the present study, this plurality of truths and stories is not considered a problem but rather is seen as an opportunity for deeper understanding.

According to the philosopher van Hooft (1997), health is an experience and a condition of subjectivity, which he defines as "the pre-intentional activity of constituting oneself as a self" (p. 24). The material dimension of health refers to all of the processes of an organism that are necessary for biological life, such as respiration, circulation, and metabolism. The pragmatic dimension of health comprises everyday practical concerns and the activities in which we engage. The conative dimension of health concerns our "reaching out of subjectivity towards the world and others" (van Hooft, 1997, p. 25) through care and desire. Finally, the integrative dimension of health entails striving for meaning, the "need to give our lives a structure analogous to the narrative form of a history" (p. 26). The notion of health espoused by van Hooft as a condition of subjectivity justifies an interest in life stories as sources of insight into perceptions of health. Life stories reflect all four of his dimensions of health, the integrative being the most obvious. In addition to providing life structure, life stories are *about* something: everyday life, care, and desire. Furthermore, life stories are embodied; they are about bodies and are told through bodies. However, research suggests that health inequities between "ethnic" or "cultural" groups are largely the consequence of

socio-economic differences (Ahmed, Mohammed, & Williams, 2007). By focusing exclusively on health as a condition of subjectivity, we risk ignoring the impact of historical, social, political, and economic factors on people's health.

Postcolonial theory provides a framework for understanding how people's health is closely related to historical, social, political, and economic factors. Browne (2005) sums up postcolonial theory as "a body of critical perspectives that share a political and social concern about the legacy of colonialism, and how this legacy shapes relations at the individual, institutional, and societal levels" (p. 69). Critics of postcolonial theory point to a tendency to focus on the presumed shared experiences of colonization among group members and a tendency to overlook the agency of "the oppressed" (cf. Browne, Smye, & Varcoe, 2005). In the present study, however, we focus on the agency of "the oppressed" by studying the life stories of elderly Sami. Based on the material presented, we argue that there is no contradiction in perceiving the elderly Sami as active and engaged while simultaneously acknowledging the impact of a history of colonization on their lives. Several scholars (e.g., Mishler, 2005; Stone-Mediatore, 2003) have advocated for considering "marginal experience narratives" that might function as *narratives of resistance*. Stone-Mediatore (2003) argues that stories of marginalized people "precisely by virtue of their artful and engaged elements, can respond to the inchoate, contradictory, unpredictable aspects of historical experience and can thereby destabilize ossified truths and foster critical inquiry into the uncertainties and complexities of historical life" (p. 9). We believe that the stories presented in this article can be regarded as narratives of resistance.

## Methods

### *Participants and Recruitment*

The 19 participants in the study (11 women and 8 men) were between 68 and 96 years of age, considered themselves Sami, and were experiencing various health problems. Of the 19 participants, 1 lived in a nursing home, 3 lived in assisted living facilities, and 15 lived in their own homes with or without help from home care services. The participants lived in two municipalities in the two northernmost counties of Norway. Both municipalities have ethnic composite populations. One municipality is part of the Sami core area and a considerable proportion of its population is Sami. The other municipality is not considered part of the Sami core area and only a small minority of its population is Sami.

The participants were recruited in two ways: through managers of local nursing homes and home care services, and through local seniors' associations. Information letters written in both Sami and Norwegian

were distributed, and people interested in learning about the study and possibly participating sent letters of consent in postage-paid envelopes. After receiving the letters of consent, we contacted the individuals to provide additional information about the study and to make appointments for interviews. Initially, 22 people agreed to participate; 3 were excluded due to doubts about their ability to provide informed consent.

### ***Interviews***

A thematic interview guide was used. All of the interviews began with the interviewer inviting the interviewee to talk about her or his life in the manner of her or his choosing. The interviewer took care not to interrupt the stories, but the interviewees varied in the manner in which they told their stories. Some participants spoke continuously without solicitation; others needed assistance, including more or less specific probes to help them continue with their stories. The interviews moved thematically back and forth between stories about the past, reflections on the present, and thoughts about the future.

The interviews were conducted either in the interviewee's home or in the nursing home/assisted living facility where the interviewee resided. The interviews lasted between 45 and 150 minutes and were digitally audiorecorded.

### ***Ethics***

The study was approved by the Regional Committee for Medical Research Ethics. The participants were limited to persons capable of providing informed consent. The participants were informed of their right to withdraw from the study without stating a reason and were assured of confidentiality.

All interviews were conducted in the Norwegian language. Sami was the first language for all interviewees from the Sami core area and for one interviewee from outside the Sami core area. Norwegian was the first language for nine of the interviewees from outside the Sami core area. Seven of the Sami-speaking interviewees reported speaking Norwegian fluently and maintained that it was not problematic for them to be interviewed in Norwegian. However, three of the Sami-speaking interviewees did voice concerns about whether they would be able to express themselves satisfactorily in Norwegian. These concerns were expressed when the interviewer, upon receiving the letter of consent, made contact to set up the interview. The interviewer then offered to use an interpreter, but the interviewees all chose to do the interviews in Norwegian. We realize, in retrospect, that the interviewer should have offered to use an interpreter in *all* interviews with Sami-speaking interviewees. We have reflected on how interviews not conducted in the first language of the

interviewees may have affected the material. This shortcoming may have influenced *how* the interviewees told their stories, because one's first language is usually richer in detail and nuance than languages acquired later in life. It may also have influenced *what* was related in the interviews. A Norwegian-speaking interviewer might be perceived as a representative of the majority society, which in turn might contribute to any distancing between the interviewer and the interviewee. Before the interviews, we were concerned that this perception would keep the interviewee from addressing issues such as assimilation and minority experiences. While this may have been so, interview material rich with descriptions and stories concerning these issues suggests that it may not have had a significant impact. The transcriptions indicate a clear willingness among the interviewees to share their life stories. During or after the interviews, all of the participants expressed appreciation for being interviewed on this matter.

### ***Dialogical Narrative Analysis***

The audiorecordings were transcribed verbatim. Field notes were recorded and were used at several stages in the research process. Following transcription, the tapes were replayed, the transcribed texts were reread to allow the researcher to become reacquainted with the material, and summaries of all interviews were written. We then began to search the transcriptions for stories. The interviewer noticed some stories during the interviews, and some stories became evident during the transcription process. However, more subtle stories, some amounting to only a few sentences, were revealed through this purposeful reading. As noted by Riessman (2008), the stories in a text often do not have clear-cut "borders," and the researcher participates in the creation of stories, rather than "finding" them in the interviews, by deciding what to present as stories.

In the present study, the stories were created in the context of the qualitative research interview and should be considered neither as direct representations of historical events nor as direct reflections of the identities of the participants. Stories are "acts of engagement with researchers" (Frank, 2005, p. 968) and are intended for particular recipients (Riessman, 2008). The stories developed from the dialogue between the interviewer and the interviewee. This dialogue continued into the analysis.

Given the nature of the study — exploring the health experiences of elderly Sami individuals through the stories they tell about their lives — a dialogical narrative analysis, as suggested by Frank (2005, 2010, 2012), appeared to be a suitable approach. According to Frank (2010), dialogical narrative analysis "studies the mirroring between what is told in the story — the story's content — and what happens as a result of telling that story — its effects" (p. 71). The purpose of dialogical narrative analysis is not

to locate themes as finalizing descriptions or statements about who the research participants are, but, rather, to capture individual struggles in all of their ambivalence and “unfinalizability” (Frank, 2005). A dialogical narrative analysis treats stories as actors. The analysis is narrative not because the stories are the data but because we study *how stories act*. Frank (2010) poses several questions that initiate the analysis by calling attention to *what the stories do*: What is at stake, and for whom? How does the story and the particular way it is told define or redefine the stakes, raising or lowering them? How does the story change people’s sense of what is possible, what is permitted, and what is responsible or irresponsible? Keeping these questions in mind, we now turn to the stories.

## **Results**

The three stories chosen for close attention in this article are not representative in the statistical sense of the word. They were selected because of their particular clarity and distinctness with regard to the issues discussed in the article: elderly people’s experiences of health as expressed through their life stories and their active engagement with colonial history in the telling of their stories. As noted by Frank (2012), the selection of stories in dialogical narrative analysis is based on what has been learned during the research process, even if a considerable part of this knowledge remains tacit to the researcher. In this perspective, the interpretation and discussion of the three stories is informed by the knowledge developed through engagement with the stories of the other participants in the study.

### ***Inga: Born in a Turf Hut***

Inga is a woman from a reindeer-herding family in the core Sami area. She says that she has been trying to live as decently as possible all her life to show that the Sami are not inferior: “Perhaps people think the Sami are not as good as other people. I think this is because they don’t know any better.” However, Inga does not believe that all Norwegians perceive the Sami as inferior: “A lot of Sami girls marry Norwegian men. Perhaps the men who are marrying Sami girls don’t see the Sami as bad.”

After making this statement, Inga starts to tell a story about her own birth. She was born around 1920 in a turf hut of the type reindeer herders used intermittently while tending their herds. In addition to her mother, her father, and her grandmother, several other people were in the hut when Inga was born. Inga’s parents were sleeping on the floor when her mother went into labour:

*Then my grandmother said, “What’s going on? The house is crowded!”  
Then my father replied, “We’re trying to bring a new human being into*

*the world.* "There was a fireplace there, and there was a fire in there. They had just cooked some meat. There were a lot of Sami people there. My father just threw away the meat broth and put water into the pot to heat it. Then I was born. My father cut the umbilical cord. And my father washed me. It was my dad who washed me! Two waters: the first water he threw away, and then another water. And my grandmother lay on the bed. They put my mother on the bed and me next to her. We stayed there for a couple of weeks before they drove away. It was just a hut of the kind the reindeer herders used. There, I was born. There were no white clothes . . . [laughs] It was my father who delivered me, and he almost washed me in meat broth . . . Vuoì vuoì! And I became human too! Nowadays the clothes are so white. Everything is so white and clean. But I was born there. [laughs] And I was healthy! I've never been sick. No nuisances. . . . I'm not sick, and I've had children myself. Lots of children. And they came so easily. That's how it is!

Inga attended residential school as a child. She says, "We had to go there, the Sami kids. Luckily, I knew the language before I went to school." If the teachers heard the children speaking Sami, they told them to stop. Inga tells a story about a teacher from the South who wanted to take Inga with her to the South:

*There was this older teacher. She came all the way from the South. . . . She had no children of her own, and she wasn't married either. She wanted to bring a Sami child to the South, to let the child go to school there, and she would pay for school for this child. . . . If I would come with her I would have my own room and she would buy me clothes and everything. She promised. And I was so happy! I could go there and attend school! But then I went home and told [my mother] what the teacher said . . . "She wants to take me there so I can learn. I can go to school there — there are lots of schools there." At first my mother didn't say anything. Then she said, "You will learn to sew Sami boots (skalla) and all Sami clothes. That's enough school for you!" She said that she would teach me to sew Sami clothes and that I would marry a Sami man, a reindeer herder. "No, I don't want to get married. Never!" I said. I told the teacher, "You have to talk to my mother!" But my mother said no. "Inga is not going anywhere! She will learn to sew Sami clothes, and she will marry a Sami man with reindeer." And so it was. I was really angry with my mother. I cried and cried, but it didn't help. The teacher took another girl, from the orphanage. . . . My mother said, "You can live from sewing Sami clothes. Not everybody can do that! But you can learn to do it." [pause] And so it was.*

There is an undertone of vulnerability in Inga's stories. In her own words, "all her life" she has been conscious of her conduct, trying to prove wrong those who think Sami people are inferior. The vulnerability contained in her lifelong fight for equality emerges in statements such as "I became human too." This is an individual expression of the history of assimilation. The story about the teacher who wanted to "save" her by taking her away from her parents and giving her the type of education, clothing, and housing that was valued in the majority society is likewise an individual history of colonization.

While Inga's stories are individual expressions of the colonial history of assimilation of the Sami, they are, simultaneously, narratives of resistance. Through her birth story, Inga resists the standards of the majority society "where everything is so white and clean." The majority society is represented by the absence of "white clothes" and a midwife, but these appear not to be missed at her birth. The birth story brings force and energy to Inga's lifelong project of proving the majority wrong. The turf hut, the delivery on the floor, and, perhaps most strikingly, the meat broth bring tremendous force to Inga's story. The statement "It was my father who delivered me, and he almost washed me in meat broth" adds strength to her story.

The story about the teacher from the South is also a narrative of resistance. In this story, it is Inga's mother who represents the resistance. One aspect of this resistance is the mother prohibiting Inga from going to the South with the teacher, but she also opposes the teacher. Given the historical and social circumstances and the power relations between a Sami woman and a teacher from the South, the mother's statement "Inga is not going anywhere!" is a strong expression of resistance. Inga is making her mother's resistance her own by including it in her life story. The tension between the majority society represented by the teacher and the resistance of Inga's mother is expressed through several binaries in the story. The teacher's tempting offer is opposed by the mother's "You should learn to sew Sami boots and all Sami clothes. That's enough school for you!" Furthermore, the teacher's enticing promise of manufactured clothes is countered by the mother's "Sami boots and Sami clothes," and Inga's prospect of having a room of her own sits in opposition to the crowded turf hut at her birth. Inga lets her mother have the upper hand with the statement "You can live from sewing Sami clothes. Not everybody can do that! But *you* can learn to do it." In this statement, Inga, through the voice of her mother, expresses the privilege of being a Sami. Anybody can go to school and wear manufactured clothes, but not everybody can learn to sew Sami clothes. Through the birth story, Inga's resistance to being inferior is expressed in the narration of her *healthy self*. The apparently frail elderly woman, nearly blind and barely able to walk,

states, "I'm not sick, and I've had children myself. Lots of children. And they came so easily. That's how it is!"

### ***Laila: No Special Treatment Wanted***

Laila was born in the early 1930s. She grew up with seven brothers and sisters in a remote coastal area. "It was a lonely spot. You had to go there by boat." She had a hard childhood, losing her father and a brother to the sea when she was only 7 years old. Laila has a congenital physical handicap, but she says, "When everything works up here [points to her head], it's okay."

Laila had to leave home and go to a residential school as a child. She says, "I can't complain about school. Lots of people do, but I can't complain. I liked school. I guess they had to be that strict . . . No, I can't complain." Laila did not speak Norwegian when she attended school: "Not knowing the language was the worst part. I didn't know when to say yes or no." She says that this was frightening, but that she was not the only one affected: "We were what I would call equal, all the children attending school then, at that school . . . There were only a few who spoke Norwegian." The children were not allowed to use the Sami language at school, but Laila says, "We did speak Sami. We did. We had a Norwegian teacher but she . . . didn't care. She was old. She was a teacher for many years. She was the teacher for all my siblings, so you can imagine how old she was."

After her Confirmation, Laila "knew enough Norwegian" to go to the nearest town and enrol in cooking and sewing courses. Despite her physical handicap, Laila had several jobs as a domestic, working as a seamstress and as a cook. "Whenever something happened — a funeral, a christening, or a confirmation — I was in charge." She says,

*I wasn't the type to lie around moping. I was active all the time. . . . I went to school and everybody was equal. . . . I wasn't the type to shut myself away. Oh no! I wanted to be out. I wanted to be in the midst [of things]. And the other kids in school — there was no bullying back then! Oh no! I was accepted everywhere, so it didn't bother me.*

Laila has been active in interest groups for people with various handicaps all her adult life.

Laila's late husband "was a kind man." He subsisted on casual work. "He had a small . . . a big handicap. He was illiterate. He didn't have any schooling . . . He had to struggle at home. . . . And they had a teacher . . . who ignored those who didn't . . . know anything."

Laila is clear about her Sami heritage. She states immediately that she is a Sami. However, she dislikes the focus on the Sami people in society: "I must say, I think it's almost too much about the Sami now. They say,

‘We are Sami, we are Sami, I am Sami, I am Sami.’ [raises her voice] No, it’s too much! . . . I think so. They demand too much. That’s the problem.”

In addition to her congenital physical handicap, Laila has used a wheelchair for the last 3 years. “It was my feet that couldn’t . . . my feet refused.” Despite all this, Laila says this about her health: “My health? I must say, my health is good. I’m satisfied with my health. Of course, I have a few small nuisances. I do. But other than that . . . no.”

Like Inga’s story, Laila’s story is underlaid with the fight for equality. Being treated as an equal is at stake throughout Laila’s life story. Although she was born with a physical handicap, her life story, in which “being in the midst [of things]” is a central theme, embodies her with a *healthy self*. To be healthy is to participate. Laila’s story about her husband is quite different. She refers to his illiteracy as “a *big* handicap.” One can easily imagine how her husband’s opportunities for participation and equal treatment were restricted by his illiteracy. Laila’s reflections on residential school life underline her emphasis on equality. She “can’t complain” about school because, after all, almost all of the children were in the same situation; few of them spoke any Norwegian when attending school. The way she describes the aged Norwegian teacher gives her and the other Sami children the upper hand. Moreover, Laila eventually mastered Norwegian well enough to take courses in the town.

We perceive Laila’s life story as a narrative of resistance. Like Inga, Laila expresses her resistance through the narration of her *healthy self*. She resists being different; she resists special treatment as a “handicapped” person. From this perspective, Laila’s indignation at “Sami activism” is reasonable. Claiming special rights is exactly what she has been refraining from doing all her life. What she perceives as Sami people “demanding too much” raises the stakes of her equality.

### ***Marit: No Need to Go to the Gym to Row***

Marit was born in the early 1930s in a remote coastal community as one of six siblings. “We lived in a spot where, I would almost say, not even birds would pay a visit.” School was one of Marit’s first encounters with society outside the home. “Imagine that it’s possible! I started school without understanding what the teacher talked about. I know I read because I had learned to spell. So I did put the letters together, but I didn’t know what I was reading! . . . No, I didn’t know what I was reading. *Now* I can read.”

Marit and the other children were not allowed to speak the Sami language at school. “The teacher said, ‘You have to speak Norwegian.’ Of course, we should have spoken Norwegian, but none of us understood

. . . If it was *today*, I would have told her, . . . but, of course, I didn't say anything. Who could I tell?"

Marit relates how the children were treated differently at school. She discusses the teacher's preferential treatment of two Norwegian brothers in her class. There were those who were not treated so well. "There were differences. None of us were wealthy, but I remember one boy who came from particularly poor conditions. I can't understand why they treated him like that . . . He was put down. But when he grew up he attended schools, and he became a writer. Now he's dead."

Marit had severe asthma as a child. She spent a great deal of her childhood ill with asthma and people would say that she was a bashful child. She says:

*I never was bashful among people speaking Sami, but I didn't speak Norwegian back then. I didn't know enough Norwegian to participate in talking. . . . I didn't know Norwegian back then. Nowadays, some Norwegians say, "We remember, you used to be here — you spoke Norwegian well." Yes, a little . . . I guess I planned for hours the things I said. That's how it was. But they should discuss with me now — because now I can talk! I'm not bashful now!*

Marit dismisses the idea that the asthma robbed her of her youth:

*A lot of people have said to me, "You had no youth." Youth? What do they mean by that? I had a youth like everybody else! While I was sick, the other youths visited. Back then, people visited! And when we went skiing, we all were together. If I was short of breath, the others waited for me. Yes, they did.*

Throughout her adult life as well, Marit has been ill with asthma.

Marit is direct and candid when speaking of her Sami heritage. She says, "We are Sami! I just think: I am a Sami. I am not at all a Norwegian. And everywhere I go I say, 'I am from here, and I am a Sami!'" She associates being a Sami with being active.

*I think it has been nice to be a Sami. When we were kids, we had to work outdoors with our parents. We didn't sit inside watching television and then have to exercise at the gym. Nowadays, people have to exercise because they're only sitting. We had to row. Row! Nowadays, people row at the gym. They do! That's the difference, if I may say so, in being a Sami.*

In Marit's story, her *healthy self* is at stake, but the stakes are lowered by the manner in which she tells her story. In Marit's story, as in Laila's, health is associated with participation. To Marit, the Sami language is essential for her participation. She denies that she was a bashful child

while among Sami and able to participate in her mother tongue. Furthermore, her severe asthma was not a problem in that it did not prevent her from socializing with the other children. The other children made it possible for her to participate by visiting her when she was sick and adjusting the speed of their skiing when she was short of breath. The stakes for her healthy self are lowered through the community with other Sami-speaking people.

As in Inga's and Laila's life stories, colonial history is evident in Marit's story, particularly in her narrations about residential school life. Similar to the two other women, Marit presents a narrative of resistance. She resists being ill and bashful, and it is her Sami heritage that is key to a healthy, participatory self. In Marit's story, her Sami heritage allowed her to engage in healthy activities such as rowing. She gains the upper hand by ridiculing people who go to the gym to row; she says that this is the difference between Sami and Norwegians.

Marit is proud to be a Sami; she states that she is "not at all a Norwegian." The history of assimilation is nevertheless present in the way she narrates her life. Statements like "Now I can read," "If it had been *today* I would have told her," and "they should discuss with me *now* — because *now* I can talk! I'm not bashful now!" suggest that the capacity to resist is at least partly contingent upon her mastery of the Norwegian language.

### **Discussion and Implications**

Life stories, such as the three stories presented above, are a source of insight into health experiences. The stories could be read through the lens of van Hooft's (1997) notion of health as an experience and a condition of subjectivity. Through such a reading, one could identify elements of all four dimensions of health: the material dimension expressed in Marit's shortness of breath and Laila's physical handicap; the pragmatic dimension expressed in rowing, sewing, and cooking; the conative dimension expressed in Laila's desire to be in the midst of the crowd; and the integrative dimension expressed in the structure and coherence of the stories. Van Hooft's notion of health is useful because it promotes a broad understanding of health that does not focus only on the absence of disease. If we focus exclusively on health as a condition of subjectivity, the key to quality care lies in the relationship between patients and health-care providers, which has been referred to as "micro-ethics" (Mishler, 2004, p. 98). From such a perspective, the call for cultural sensitivity and culturally congruent care, understood as "culturally based care knowledge, acts, and decisions used in sensitive and knowledgeable ways to appropriately and meaningfully fit the cultural values, beliefs, and lifeways

of clients” (Leininger & McFarland, 2006, p. 15), in encounters with Sami and other minority patients appears reasonable. However, if people’s experiences of health are perceived as also having historical and socio-economic influences, such a “micro” perspective is too narrow. We argue that the study of people’s life stories allows for an examination of their health experiences as a condition of subjectivity and as influenced by historical and socio-economic contexts. The stories are, of course, subjective accounts, but they occur “at a historical moment with its circulating discourses and power relations” (Riessman, 2008, p. 8), which are echoed in and have an impact on what can and cannot be told in the individual stories. A collective history, such as the history of assimilation and colonization, has effects at the individual level (cf. Adelson, 2005), and post-colonial theory provides a framework for understanding how present-day experiences are shaped by history (Browne et al., 2005).

The women’s Sami heritage has a central place in all three stories and is closely connected to their experiences of health, not necessarily because being Sami implies that the women have certain cultural traits in common, but because being Sami in this particular historical period may have produced experiences that persons from the majority group would not have. In this sense, the legacy of colonialism is inevitably present in the women’s stories. This is evident in all of their stories about residential schools and being forbidden to speak their own language. The experience of belonging to a stigmatized minority group is evident in the way that Inga, by being constantly conscious of her conduct, takes responsibility for how all Sami are perceived by the majority population. A person belonging to a non-stigmatized majority would not necessarily feel responsible for the reputation of the whole group. Herein, perhaps, lies a key to Laila’s indignation with Sami claiming special rights: The special rights of some Sami representatives brand the Sami as a group of people with special needs.

Health-care providers who focus on Sami and other minority patients exclusively as minorities or cultural “others” risk ignoring the agency of their patients. From such a perspective, patients are “products” of their culture and even passive victims of the majority policy. Postcolonial theory calls attention to the impact of historical and socio-economic factors on people’s lives and forestalls attempts to represent these as issues of “cultural difference.” Narratives of resistance, such as those presented in this article, illustrate that people are not necessarily passive victims of the legacy of colonialism; on the contrary, they are expressions of the agency of “the oppressed.” Resistance is not a passive state but an active process, as is health. The importance of considering Indigenous people as active in response to their colonial situation, rather than simply as passive victims, is described elsewhere (Adelson, 2005). According to Frank

(1995), “the truth of stories is not only what *was* experienced, but equally what *becomes* experience in the telling and its reception” (p. 23; original italics). Such stories are a means for people to take control of their own representation (Stone-Mediatore, 2003).

Through their narratives of resistance, the participants in this study become the narrators of their own stories without completely becoming the authors of their lives (Ricoeur, 1986). They cannot change the historical and social settings of their life stories, but they certainly do control the part that these settings play in their stories. As noted by Stone-Mediatore (2003), narratives of resistance can destabilize ossified truths and thereby suggest that historical life might be more complex than it appears at first glance. One example is Marit’s ridiculing of Norwegians who go to the gym to row. Another is Inga’s dismissing of the whiteness and cleanliness of modern maternity care. Yet another expression of resistance is Laila’s indignation over special treatment for Sami people. According to Ewick and Silbey (2003), narratives of resistance reveal the tellers’ consciousness of how opportunities and constraints are embedded in the taken-for-granted structures of social action. This is evident in Inga’s story about her mother opposing the teacher from the South. While telling the story of her mother standing up to the teacher, Inga makes known her consciousness of the opportunities and constraints embedded in social structures. The firm “Inga is not going anywhere” reverses the power relations between the Sami woman and the teacher from the South. Likewise, Marit’s story about the tormented boy who grew up to be a writer demonstrates awareness of opportunities and constraints. The present study illustrates that a narrative approach to issues with respect to health and the Sami people unveils “truths” other than those described in statistics on mortality rates and disease incidence. Health is not a passive condition but an active process. The stories of these three women indicate that being a healthy self can be an act of resistance.

In this article, we have argued for the need to combine micro and macro perspectives when grappling with issues regarding Indigenous people, health, and health services. The micro perspective focuses on the face-to-face encounters between health-care providers and Indigenous patients, while the macro perspective demands a contextualization of interpersonal encounters. The narratives of resistance discussed in this article illustrate the importance of recognizing that the legacy of colonialism is present in the lives of Sami elderly today without regarding them as passive victims. Such narratives of resistance demonstrate that envisaging Indigenous elderly solely as passive victims and ignoring their role as active agents is not only insufficient but offensive. Resistance is a resource that should be appreciated by health services both at a systemic

level — for example, through authentic partnership with Indigenous elderly in the planning and shaping of services — and in individual encounters between patients and health-care providers.

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