TSLEIL-WAUTUTH HEALTH, SICKNESS, DISEASE AND TREATMENT:

AN EXPLORATORY ETHNOGRAPHY

by

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ABSTRACT

The theologically based healing practices of Canadian First Nations people has begun to receive attention from a variety of people: scientists, therapists, health care practitioners, ecologists and academics. This apparent wholistic ideology is considered to be a forerunner to health care maintenance and preventative therapeutic interventions in terms of the process of healing amongst certain groups in Canada. Nonetheless, Status Indian people in Canada continue to experience greater rates of disease, mortality, and social ills than the average Canadian citizen.

This research project focusing on the Tsleil-Waututh First Nation citizens involves experiences with sickness, disease, health and treatment. It observes and translates the peoples' health care experiences beginning with experiences of historical relationships within their contexts, the influence of religion, the evolution of those relationships, and the decisions that influence health care choices both past and present.

This study is relevant to social work because it provides a community specific example of culturally interpreted explanations of health care practices and experiences both past and present.

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A word of caution for those who may possess the desire to conduct an investigation such as this: if you are uncomfortable with vulnerability, this is not for you.

Chapter I

INTRODUCTION

Social work practice is concerned with helping individuals to meet their unique and diverse needs within the strengths and confines of their environment. It incorporates a variety of knowledge, values and skills in order to perform this function (Compton and Gallaway, 1979; Anderson, 1981; Morales & Sheafor, 1986). As a growing profession evolving with an era of societal change, social work is concerned with the task of improving the profession's repertoire of skills by enhancing social work knowledge by creating innovative, contemporary skills to meet the changing needs of human beings.

Cross cultural counselling techniques have recently become a part of the repertoire of skills of social workers as an indication of this profession's commitment to meet human beings' changing, diverse needs. Derald Sue (1981) contends that counselling in general reflects the values, beliefs and biases of the dominant (European) society. The dominant society, in most situations are those people who are a majority in terms of race rather than gender. Counselling, in general, has failed to recognize that the very tools used to enhance life for the majority can also be tools of oppression for the minority person. Due to different value and belief

systems and opposing socio-political backgrounds, the minority client has in most situations been further victimized within counselling relationships because of stereotypes. The inability of the non-minority counsellor to fully comprehend the internal systems and resources of the minority client has caused the counselling relationship to stagnate and oftentimes terminate because of such cultural differences.

The social work profession in Canada has lacked appropriate cross cultural counselling techniques that has influenced the type and quality of practices provided to the Aboriginal client. The non-Indian social worker possessed different values, resources, belief systems and different socio-political backgrounds that have influenced the type of intervention provided to Indian people that has caused First Nations communities to develop a mistrust for social workers, in general. Based on the First Nations' previous experiences of culturally inappropriate social work intervention practices, Canadian First Nations collectively have been disempowered by the social work profession which is an indication of the colonized state of Aboriginal people.

Patrick Johnston (1983) has documented the effects of the lack of cultural understanding for First Nations communities. He has examined how the differing value systems of Indian and white people have led to the unnecessary apprehension of Indian children. In Canada this practice of inappropriate apprehension has been coined the 'Sixties Scoop'. This

involved the apprehension of Indian children based on the value system of the white social worker who possessed a high regard for material possessions while neglecting to recognize and utilize the Indian's interpretation of material wealth: the family and community.

This apprehension (Sixties Scoop) of Aboriginal children has been referred to as cultural genocide by the citizens of Canada's First Nations because it has created and disempowered a new breed of Indian people. These children are raised in the non Indian social workers world learning their values, belief systems, utilization of their resources and socio-political background; yet they do not belong to the white society because of their obvious physical racial differences. They also do not possess the knowledge to belong to their own people because they are not taught the fundamentals of Indian life since they are raised in a non Indian society. If the Aboriginal child is returned home, he/she cannot be prepared for the cultural transition from white society to Indian society by the non Indian social worker because of the lack of cross cultural counselling techniques. This relationship of mistrust of social workers by Indian people has created a challenge for the social work profession to create techniques sensitive to Aboriginal people in order to meet their needs.

Little attention has been provided to counselling the Indian client in health care settings although it is known that Indian people in Canada experience higher rates of social

ills such as suicide, alcoholism, drug abuse and violent death (National Health and Welfare Report, 1988; York 1990). Often, the historical and socio-political experiences of the First Nations citizens have either been neglected or misunderstood.

Most Canadian people do not understand the impact of the legislative policy, the Indian Act, on the lives of First Nations citizens, nor do they understand how the natural systems of Indian people were destroyed by the dominant society and why. To be able to make sense of why Indian people select certain health care strategies or refuse health care services or treatment, it is important to understand the history of Indian people in a general socio-political sense. Usually, refusal of European health care services is more than simply a cultural matter, at times it is the limited selection of choice that Indian people feel they have because of their colonized state in Canada. Other times, choices are simply cultural with no further need to explain, from an Indian perspective. During situations such as this the non Indian social worker needs to be sensitive and adhere to the social work value of the person's right to self determination.

As the literature review will demonstrate, it is the lack of the white person, whether a social worker or another type of helping profession worker, to fully comprehend the historical background of Indian people and all of its implications that have led to stereotyping the Indian client into a neat "cultural category". This explains why

counselling or social work interventions were not utilized by the Indian client and more damaging, justifies inappropriate social work practices, such as the "Sixties Scoop".

The term 'native' in Canada is used to describe three different Aboriginal groups. These groups of people are: the Metis, offspring of Indian/white parents; Inuit, formerly known as Eskimos; and the Status/Treaty Indians, those First Nation people recognized as Indian under the Indian Act who may or may not possess an Indian Treaty. This research project involves an ethnographic study that is exploratory in nature. It concentrates on the experiences of one Canadian First Nation of Status Indian people--in particular, On-Reserve Status Indian people. It is imperative to make this distinction between the three major 'native' groups because each of the three groups possess a different collective relationship with the Canadian government and history within this country, Canada.

The terms: 'First Nation citizen', 'Aboriginal' and 'Indian people', will be used to generally describe the background of Indian people throughout the literature review. These terms will also be used to describe the study population, as will the specific names 'Coast Salish' and especially: 'Tsleil-Waututh'.

European people initially began documenting the lifestyles of Canada's First Nations citizens upon the 'discovery' of these peculiar, brown-skinned people. The

explorers who first began this process of documentation were in awe of these strange peoples simplicity of living. These brown-skinned people did not possess the same quality of technology of the explorers: yet, these people managed to hunt, quite ingeniously, large game such as bear or buffalo. They spoke different languages but managed to communicate among different Aboriginal societies using sign languages. In addition, the mechanisms for recording history differed from the European because Aboriginal history was preserved and recorded in oratory form by use of ceremony to provide for community witnessing to ensure what was being recorded was true and accurate.

From an European perspective, because the Indian people suffered from lack of exposure to the Christian word, it became the missionaries' task to bring salvation to the Aboriginal society by destroying their pagan religion in which they worshipped a variety of 'gods'. Finally, the Indian did not appreciate the value of the resources found in the land: the variety of commodities that could be acquired from the animals. The European people took it upon themselves to "rescue" these poor savages.

During the process of European rescue, Indian societies were dislocated from their natural environment. With the introduction of European technology, Indian societies were also introduced to a foreign, malicious commodity: European disease. Disease that was not only alien to Indian societies

but disease for which the Indian people possessed no immune system resistance. Aboriginal pharmaceuticals consisted of herbs and roots which the Indian people used to help cure diseases the European people had contracted during their voyage--for example, scurvy.

In combination with the bizarre, abnormal (European) disease, the Christian word was introduced to Indian people, especially the power of the Bible's written word. In combination with the power of the Bible was the use of instruments from the Indian's natural world. Assimilation of Christian rituals such as Baptism that utilized water, a basic ingredient of Aboriginal theology and health care allowed for the Indian to participate in the process of European salvation (Hallowell 1955). The missionary's task was to sow the souls of the savage. This occurred during a period when the Indian was most vulnerable. Thus, the seed to colonize Canadian Indian people was planted.

In an attempt to nobly conquer Canada's First Nations, a variety of policies were instituted by the British Monarchy that began with the Royal Proclamation of 1763, since the Indian people still possessed the military force to be feared, followed by the British North American Act 1876 and Indian Treaties that legally acquired Indian land, from a European perspective. That led to the creation of the Indian Act, originally enacted in 1868. The Indian Act continues to be an active legislative policy that was devised to implement the

content of Indian Treaties whose policies control every aspect of Indian life: from health care to education, housing to travel, the Indian was now the property of the European.

The explorers' and missionaries' documentation of Indian societies were followed by a variety of scholars such as anthropologists, ethnologists, botanists, and in recent times Indian authors. Based on these documentations, it is known that prior to the arrival of European people, Indian societies were relatively free of disease. Any disease that Indian people did experience, death did not occur in epidemic form. Epidemics, in general, did not occur and death was the result of natural causes based on the environment of these people. When European people 'discovered' Indian societies, they were in awe of the physical beauty of these brown-skinned people. They admired their straight white teeth and their physical stature. In fact, Indian societies practised a level of hygiene (e.g. Sweatbaths, swimming, etc.) that the European had not yet attained.

It is also known, based on scholastic writings (Adams, 1975; Hallowell, 1955; Martin, 1978, Nikyforuk, 1990; York, 1990), that Aboriginal theology was important to Indian societies; that their forms of theology were practised ritually and ceremoniously; that tabu played a major role; and, finally, that their forms of theology were used to promote and maintain health among Indian people.

In recent times, it has been documented that Canada's First Nations people experience enormously higher rates of disease and social ills than the majority of Canadians (Brady, 1983; National Health and Welfare, 1988; York, 1990). Part of this phenomenon has been attributed to their socio-economic status in Canada. The behaviours that display their social ills have been categorized as being part of the culture of poverty and to a larger extent the perception that the culture of Indian people is deplorable. Although, it may be true to some extent that the theory of the culture of poverty does exist among Indian societies, it is a misconception that Indian people are culturally indigent. In fact, it is largely because European people have misinterpreted the values, beliefs and systems of Indian people that has created the myth of the stoic Indian in all of its naive complexity. It is unfortunate for Indian societies that this myth has been used to culturally stereotype Indian people as "welfare-drunks seeking hand outs from the government" (Adams, 1975, p. 4 & 11; Cardinal, 1969 ,p. 5; Penner, 1983, p. 12).

Currently, First Nations citizens experience higher rates of disease and social ills and live in substandard housing that contributes to the infection and spread of disease. Socio-economic factors that influence their unhealthy state are difficult in terms of access and availability of resources, higher rates of unemployment that they experience consistently, and being constantly in need of resources to

assist in building long term economic durability. It is also a fact that Indian societies did not reach such levels of poor health until after the arrival of European people (Brady, 1983; Frederes, 1985; York, 1990; Schylynk, 1985). The question is: what influences First Nations people today?

Chapter II

LITERATURE REVIEW

The First Nations citizens in Canada, or more commonly known as Status Indian people, experience greater rates of mortality compared with the national Canadian average. In a 1988 report published by the Minister of National Health and Welfare: Health Indicators derived from vital statistics for Status Indian and Canadian Populations 1978-1986, the major causes of death among the Status Indian population were categorized as diseases of the circulatory system; injuries and poisonings; neoplasm (cancers); diseases of the respiratory system; and, diseases of the digestive system.

Two types of rates were used to describe mortality: crude mortality, and age and sex adjusted mortality. The crude mortality rate illustrates the actual occurrence of mortality among the Status Indian population. Although this rate is below the Canadian rate it illustrates that the Status Indian population is younger than the Canadian population. The age and sex adjusted mortality rate represents the mortality rate that the Status Indian population experiences at the same ageas the Canadian population. Status Indian people's adjusted rate is 40-50% higher than that of the Canadian people.

Death from injuries and poisonings is the second leading cause of death for the Status Indian population while it is only the third leading cause of death among the Canadian population. It occurs among the Status Indian population at four times the Canadian population rate. Mortality rates for diseases of the respiratory system occurs at a higher rate among the Status Indian population although during the period studied there was a downward trend. Mortality rates for diseases of the circulatory system and digestive system occurs at equally and similar rates respectively while neoplasm occur at a rate below the Canadian rate. From the periods 1982-1985, the mortality rate for the Status Indian population was approximately four times higher than the Canadian rate.

TABLE 1

CANADIAN AND STATUS INDIAN AGE- AND SEX- ADJUSTED MORTALITY RATES *
PER HUNDRED THOUSAND POPULATION, 1978-1981 AND 1982-1985 AVERAGES **

	1978-1981			1982-1985			PERCENTAGE CHANGE BETWEEN TIME PERIODS	
	IND.	CAN.	% ***	IND.	CAN.	%	IND.	CAN.
CIRCULATORY SYSTEM	313.8	344.3	91%	315.0	301.2	105%	0%	-13%
INJURIES AND POISONING	278.1	64.3	432%	218.2	55.0	397%	-22%	-14%
NEOPLASMS	118.5	168.0	71%	120.5	171.1	70%	2%	2%
RESPIRATORY SYSTEM	102.7	46.5	221%	90.6	49.9	182%	-12%	7%
DIGESTIVE SYSTEM	70.8	28.9	245%	49.2	26.1	189%	-31%	-10%
ALL OTHER	201.3	74.2	271%	174.4	73.9	236%	-13%	-0%
TOTAL	1085.2	726.1	149%	967.9	677.2	143%	-11%	-7%

* ALL AGE- AND SEX- ADJUSTED RATES ARE ADJUSTED TO THE CANADIAN POPULATION DISTRIBUTION OF 1981.

** THE STATUS INDIAN MORTALITY RATE FOR 1985 DOES NOT INCLUDE PACIFIC REGION.

*** THIS MEASURES THE STATUS INDIAN RATE AS A PERCENTAGE OF THE CANADIAN RATE.

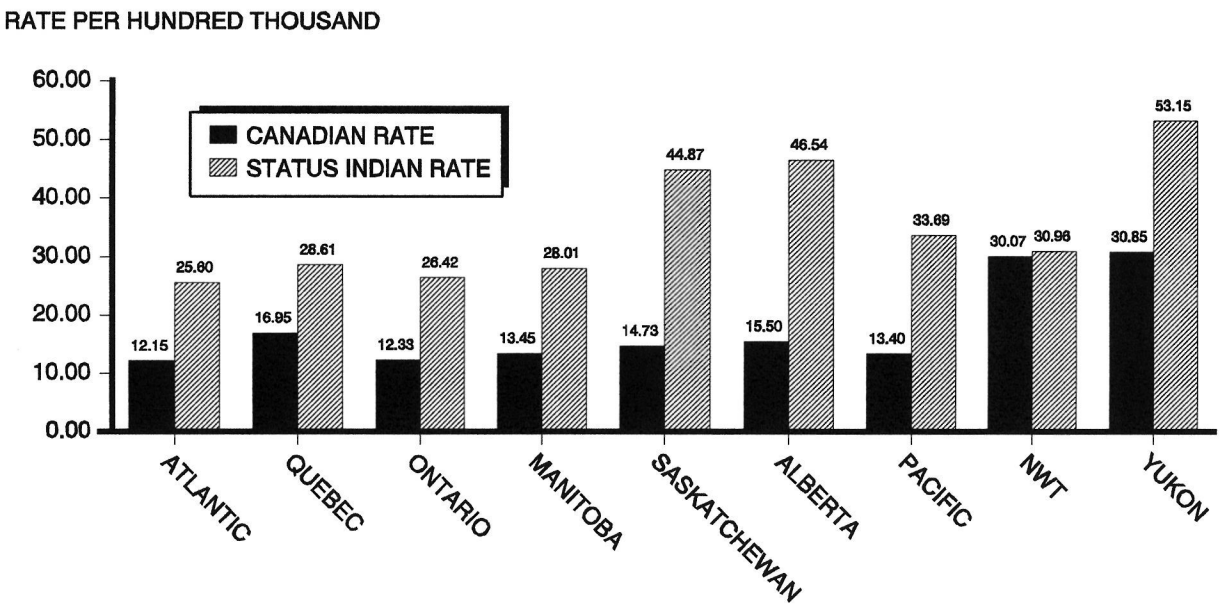
(SOURCE: NATIONAL HEALTH AND WELFARE SEPTEMBER 1988 REPORT: HEALTH INDICATORS DERIVED FROM VITAL STATISTICS FOR STATUS INDIAN AND CANADIAN POPULATIONS 1978-1986).

In addition, suicide occurs at a greater rate among the First Nation citizens. Young males, between the ages of 20-24 are at particular risk. However, the difference between both study populations is that Indian men continue to be at risk until age forty. Indian women also experience a higher rate of suicide compared to the Canadian population with the major difference being prevalent during early adulthood. Again, the crucial difference in the suicide rate between both populations is that Indian women continue to be at higher risk until age sixty.

TABLE 2

REGIONAL AGE- AND SEX-ADJUSTED SUICIDE RATES **

CANADIAN AND STATUS INDIAN, 1982-85 AVERAGE



* THE STATUS INDIAN MORTALITY RATE FOR 1985 DOES NOT INCLUDE PACIFIC REGION

** AGE- AND SEX-ADJUSTED RATES ARE CALCULATED USING THE RES.CAN.POP. OF THE CORRESPONDING YEAR

SOURCES: STATISTICS CAN. CAT. 84-206
MEDICAL SERVICES BRANCH STATISTICS

The 1988 study reveals that the First Nations citizens in Canada are dying at a younger age than the majority population of Canada. Death occurs more rapidly among the Status Indian population while perhaps experiencing a higher rate of disease.

Sociologists have studied this phenomenon contending that there is a correlation between the socio-economic status of Indian people and their poor health condition. This involves the examination of living conditions, in general. Over-crowded housing, lack of adequate water and sewage conditions, nutrition, economic resources, availability of and access to health resources all contribute to the poor health status of Indian people who live in an industrialized country (Frideres, 1985; Brady, 1983; Fritz and D'Arcy, 1983; O'Neil, 1981; Grescoe, 1981; Dosman, 1972). Of particular relevance, these authors document the historical and political aspects of Indian-white relations in Canada, especially the institutions of control such as the Department of Indian Affairs. This institution is of importance since an examination of its influence describes the process of the colonization of First Nations citizens that began with Indian Treaties and was re-enforced by the Indian Act whose policies were administered by the government appointed Indian Agent at his discretion. As Dosman (1972) contends, the study of Indian people in Canada must begin with an examination of the institutions that

dominated Indian people, and the society that destroyed the Indian.

They have documented Aboriginal people's mortality and morbidity rates and the influence of nutrition. For example, in his study of Indian health conditions, Grescoe (1981) found that Indian people suffered from severe diet deficiencies, especially vitamins. The Indian populations' vitamin consumption that were originally acquired in their diet of natural foods (e.g. fish, wildmeat, berries) were absent. He also found epidemics of gas-sniffing prevalent among children; deaths caused by disease such as gastroenteritis and pneumonia; bowel infections such as shingella that was aggravated by inadequate toilet facilities, which although it does not increase the mortality rate of Indian children, white children are rarely infected by the disease; high incidents of hepatitis that has influenced the rate of mortality among Indian people; outbreaks of tuberculosis that was tied to lack of proper housing; and, environmental pollution.

In terms of environmental pollution and its affect on the health status of Indian people, Shkilnyk (1985) has documented the injury experienced by First Nations citizens that was caused by mercury contaminated fish found in the English-Wabigoon Rivers. A change in their diet from protein-rich game and fish to food rich in starch and sugar caused Indian people to lose their natural source of vitamins. This shift in food decreased the people's protein intake and

increased their fat intake; carbohydrate intake was increased in quantity as opposed to the natural consumption in limited amounts. Shkilnyk also found that this change in diet decreased breast-feeding and increased bottle-feeding.

Furthermore, she found that changes in diet created new health problems for Indian people that led to diseases that had been rare or absent among Indian populations such as gallbladder disease and diabetes. Some of the new health problems created were obesity, acne, vitamin deficiencies, anaemia and excess fat and cholesterol levels (Shkilnyk, 1985, pp. 156-158).

Indian authors have documented the impact of the colonization process with reference to the health status of Indian people. In particular is the documentation of the prohibition of Indian ceremonies, under the auspices of the Department of Indian Affairs at the request of missionaries. These prohibitions were made legal under the Indian Act. The historical economic venture that encouraged the dismantling of the natural health care system of Indian people was the Fur Trade (Adams, 1975; Cardinal, 1969; Manuel/Posluns, 1974; Purich, 1986).

It was during the Fur Trade that a vacuum was created in the natural health care system of Indian people. Prior to the arrival of European people to Canada, Indian people possessed their own health care system. This system was comprised of practitioners (medicine people), pharmaceuticals (herbs and

roots), institutions (Sweatlodges, Long houses), ritual, ceremony and tabu. However, this system was interlocked with other systems of education, government and the economy of Indian people.

The fundamental aspect of these systems of Indian people was its "theological" foundation. Each system was interdependent and based on their form of "worship" while control of these systems remained in the hands of the "Creator" (Adams, 1975, pp. 16-18). As the Europeans arrived with their trade goods of modern technology in hand, e.g. horses, knives, kettles and guns, they also carried with them a different kind of commodity: European disease. The diseases they marketed infected the unsuspecting Indian people. As Adams contends, these European trade goods were often faulty commodities. That is, spoiled food resulted in disease, defective guns injured or killed Indian men, and disease-infected European clothes spread smallpox, pulmonary ailments and skin disease among the Indian people (p. 21).

The most devastating affect of these European diseases was the degree of infection it reached: epidemic. These epidemics occurred within Nations who were not only unfamiliar with such diseases but who also did not possess the immune system to combat the pestilence. Thousands, if not millions of Indian people were killed by these epidemics (Adams, 1985; Cardinal, 1969; Culhane-Speck, 1986; Martin, 1978; Manuel/Posluns, 1974; Parnell, 1976; and Purich 1986). These

diseases decimated Indian populations while also destroying the Indian's spiritual structure.

Health care problems that were naturally found among the Indian societies, according to studies that relied mainly on bones, are pinta, yaws, syphilis, hepatitis, encephalitis polio, limited cases of tuberculosis (not necessarily of the pulmonary type), rheumatism, arthritis, limited intestinal parasitism, gastrointestinal illnes, respiratory infections and "other" ailments. These diseases/disorders did not appear to impact on the Indian societies with the same severity as European diseases. The major causes of mortality during this time were attributed to hunting accidents, drowning, burns, suffocation, exposure, death caused by animals, cannibalism, infanticide, sacrifice, germicide, suicide, homicide and warfare (Martin, 1978, p. 48).

Prior to the arrival of Europeans the primary cause of illness was attributed to the human's failure to perform a prescribed ritual or to adhere to a particular tabu. In his book, Keepers of the Game Indian-Animal Relationships and the Fur Trade, Martin (1978) describes the decimation process. He contends that, originally, Indian people shared an interpersonal relationship with the land and all of the "inhabitants"'. Animals, rocks, trees, water and virtually everything found in their world, including air, were viewed as living beings. Animals resided in societies similar to humans and "acted in accordance to the norms and regulations of

kinship" (p. 34). The fundamental element of the relationship between man and his total environment (e.g. animals, plants, water, etc.) is the phenomenon of "power"--the spiritual force linked to an object or a natural occurrence whose energy made the world alive and in interaction with man. The secondary component of this fundamental element of their world view that humans and animals were cohabitants was that the Spirits (power) conversed with humans and used the same medicines that they provided to humans. It is within this spiritual medium that the regulations governing Indian life emanated: tabu. Tabu served the purpose of control mechanisms within their societies (p. 35). For example, when preparing food, special attention was given to the disposal of animal remains because of the fear of offending the Spirit of the animal who had allowed himself to become food for the humans. The tabus of Indian people dictated how humans interacted with their environment; and, strict adherence was ensured based on their belief reciprocity.

The Indian practitioner (medicine person) in particular was placed in a position of double jeopardy because she/he was at risk of contamination to these European diseases while being disconnected from his position of healer within his community. As the Indian societies health care practitioner, she/he utilized their natural pharmaceuticals of roots, herbs and other plant parts, ceremony, ritual and tabu while combining the functions of a psychotherapist as part of

treatment (p. 38). With the introduction of the abnormal European diseases that the Indian practitioners were unable to treat or promote a cure for, their position as practitioner shifted.

According to the Indian world view, success or failure in life was dependant upon the "power" that was equated with the tools for the task at hand. To the Indian, Christianity, in particular the missionary with his Bible, now possessed more "power" than their own natural systems: the Indian practitioner and her/his ineffective tools (ceremony, herbs, etc.). Consequently, the missionary fulfilled the role of practitioner, thus, the door to colonize the Indian was opened with Christianity.

Although the Indian practitioner had been removed from her/his role as healer, providing room for the missionary with his religious paraphernalia, "...the missionary was successful only to the degree that his power exceeded that of the shaman" (Martin, 1978, p. 58). That is, Indian victims of these European diseases were known to abandon their natural health care practices because of their practitioners (medicine people) inability to produce a cure. However, there exists a controversy regarding the degree to which the Indian people actually abandoned their natural, theology-based health care system. In summary, the Indian peoples' argument was that even in the face of death, Indian people continued to adhere

to their practice of kinship while European people practised competition.

After the arrival of European people and their new diseases, smallpox and influenza caused the mortality rate among Indian people to increase. Of particular risk were people in the fifteen to forty-year age groups. Breast fed infants were at risk because of the practice of long-term nursing within Indian societies combined with exposure to the viruses. When the European diseases infected the Indian population, the contagions usually occurred in "clusters". This means that the Indian people were combating more than one disease at a time. A contributing factor to the spread of these diseases was the panic of the infected Indian people. One example is the Indian treatment of the"'Sweatbath", as part of this treatment required immediate submersion into water (e. g. stream, lake, ocean) that sometimes further weakened the Indian person whose death was then caused by drowning (Martin, 1978, p. 50-51). Co-incidently the natural health care practices of the Indian people appear to have increased the devastation of the disease. For instance, there did not appear to be a concept of "quarantine" among these Nations during epidemics.

The tension created by European diseases, Trade, trade goods and Christianity combined to dislocate the Indian from his natural world (Martin, 1978, p. 60-61). This change in creation allowed the Indian to become a partner in the new

economy of that time, the Fur Trade, with the result of further withdrawing the Indian from within his world. The Indian was now taking the life of his "brother" (animals) for the purpose of trade as opposed to need (e.g. food, clothing). Tabus were being neglected which increased the impact of the evolution of the diseases in terms of his world view. The humans and the animals now stopped conversing: the Indian world was becoming inarticulate (p. 62). Martin writes: "The Manito [power] of the Indians had lost their protective powers--and the Indians knew it" (p. 100).

Anthropologists have also documented the health care systems of Indian people. Their documentation has concentrated on the "religious" component of the natural Indian health care system. For example, Gaddis (1977) has documented the different kinds of healing Indian societies utilized for physical illness or disease. There was healing by ritual and song, healing by herbs, and healing by herbs and ritual, to name a few. The healing ceremony was performed by only the medicine person whose role changed with each ceremony. The different roles of the medicine person included the functions of a priest, philosopher, family counsellor or physician (p. 151, 152).

In contrast, Driver (1957) has documented the spiritual ceremonies of the Indian health care system. This type of ceremony was performed specifically for the purpose of spiritual health care. For example, he has documented a

salmon ceremony performed by the NorthWest Coast and Plateau Indian people. This particular ceremony involved spiritual ritual but had no direct relationship to physical healing--its purpose was the observance of tabu. The essence of this of ceremony was to honour the first catch of salmon whose Spirit would encourage other salmon to provide themselves as food for their relatives: in this case the humans (p. 256).

Botanists and ethnologists have also studied Indian societies with particular attention focusing on the source of Indian herbs, roots, etc., or the pharmaceuticals within their health care systems. These studies examine the source of the medicine, e.g. trees and plant life, as opposed to recognition of its utilization as pharmaceuticals within Indian health care systems (Bell, 1969; Parnell, 1976; Stark, 1989; Turner & Turner, 1988; Vestal, 1973; and Vogel, 1970). In studies where recognition is given to the roots, herbs, etc., as pharmaceuticals it is concluded that utilization of these occurred in primitive and obsolete practice that was part of the religion of Indian societies in general. The implication of such studies is that since the inherent theology of Indian societies is now defunct, so is the use of such herbs. The exception of such studies is Vogel (1970) who acknowledges the contributions of Indian herbs to the larger pharmaceuticals of the health care system in the United States.

Considering a generic supposition regarding the idea of health care, history itself inspires the focus of the study of

human well being. The survival of human societies throughout the world may be considered dependent on the patterns of disease especially as related to epidemics and plagues. The evolution of health care practices and services then may be considered to be influenced by changes in the health care system due to the effects of such health crisis issues. For example, changes in old viruses or introduction of new ones, changes in the transmittance of the germ (e.g. from rats to the cough), and changes in availability of human resources (e.g. food, clean water) all contribute to the search for a cure to produce a disease-free society. From medieval to contemporary time European societies ideas of health care, both in terms of theory and service provision, have revolutionized its health care ideology that began with the thinking that God sent the pestilence thereby requiring healing and searches for cures through the church, to the scientific thinking of germs that required examination of the contagions of the body without assistance from God (Nikyforuk 1990).

Due to such incidents of human catastrophes (plagues and epidemics) European societies health care models concentrate on providing services that seek to eliminate the cause of disease (biomedical model). Perhaps, as a consequence of such thinking, the primary emphasis of the biomedical model is the secular study and treatment of disease because health is perceived as absence of disease. The cause of disease then, is

sought through the examination of the biochemical and organic functioning of the body with intervention being provided by external means.

Currently, the European (Western) change in thinking extends beyond the boundaries of the traditional scientific perspective of the biomedical model, with its primary focus of cause and effect encouraging the division of treatment for the body without consideration of the human mind that searched for a cure. That has evolved to consider the process of healing that is able to perceive health of human beings in their entirety (holistic) rather than focusing primarily on the illness/disease itself (McDonald 1990; Coburn et al 1981). The broadening of the scope of Western thinking has flourished to embrace the analysis of the health of human beings through the investigation of his total environment. The social, political and interpersonal systems also includes consideration of the cultural world view of humans especially as related to the differences as part of health care mainly in terms of religion: the ecological perspective (Germaine, 1984). As part of this trend, health care systems of different societies have begun to be studied within a cultural context.

Kleinman (1980) may be considered the pioneer of such changes in thinking regarding differences in health care systems culturally. Through his medical ethnographic investigation of the health care system of American and

Chinese people he examined the process of how the people in a particular social setting think (beliefs) about health care. The beliefs about sickness and patterns of behaviour he contends are governed by cultural rules that form those activities that are influenced by the total environment of the person: social institutions, interaction settings, interpersonal and patient-family relationships, economic and political constraints and availability of treatment (p. 26).

Kleinman had intended his study to encourage other studies of health care to expand the knowledge of health care practices cross-culturally (of different peoples). He argues that anthropologists and most ethnographers have isolated their studies of indigenous healing because exotic folk healers and healing rituals were studied for their symbolic and religious meaning rather than their medical interest. As a consequence, indigenous practices were not examined as a health care system (p. 28, 29). This type of cross-cultural work, he contends, has frustrated the development of the holistic perspective on disease and health care in any given society and has had little significance for the basic issues of medical and psychiatric practice.

From the Aboriginal perspective the biomedical model eliminates two core instruments of healing of health care: the mind and the spirit. Absence of these core instruments sets both cultural perspectives of health care opposite each other. A major discrepancy in terms of the view of health between

both societies is that the European perspective functions from the assumption that health must be concerned with germs and cleanliness, while the Aboriginal perspective maintains that health results from harmony with Nature.

In the Aboriginal community, the Indian realizes that the world is made up of both positive and negative elements which necessitates the connection for culture, religion and medicine to be interrelated. Illness is thought of as disharmony with the universe: man and Nature with all of its inhabitants. Health and well being is achieved through the process of living synchronised with Nature. Because Nature is spiritual, the absence of spiritual concerns and failure to co-operate with Nature are considered explanations of poor health that affects the human physically, spiritually and psychologically. For Aboriginal people, spiritual values were provided from their relationship with the Great Spirit (God). It is from this relationship that the Aboriginal holistic ideology of balance of all elements within the universe in relation to man, that requires the of healing the body and spirit, together (Gilliand et al, 1988).

The Medicine Wheel or the Wheel of Life is an Aboriginal symbolic circle of the universe which maintains all the relationships of all its inhabitants. It is comprised of the four directions with each direction representing the four human races, four human characteristics and basic elements necessary for survival and a human element. For example, the

East is yellow, symbolic of the Asian people, the sun, fire and the human creative Spirit (spiritual). The South is black, symbolic of Black people and represents water and emotions (emotional); the west is brown, the place of Mother Earth, Indigenous people and human intuition (mental)--the place of magic and dreams; the north is white, symbolic of European people, it represents air and the human mind filled with wisdom as humans learn about the mystery of life (physical).

The simplicity of the Wheel of Life prevented a multitude of complications within the human body and spirit. Human beings were taught to respect their bodies by eating the proper foods in adequate quantity to nourish the body while conditioning their body and minds through participation in ceremonial and traditional activity.

There exists a complex mixture of ceremony and traditional activities in the Aboriginal community that range from highly spiritual to basically social and recreational. The primary function of ceremonial healing is to restore harmony with Man and Nature. Ritual, tabu, custom and tradition all form together to govern how people live on a daily basis as taught by the Creator through human teachers, healers and leaders of the Aboriginal community. Ceremonial healing, for example, consist of Sweatlodges, Pipe ceremonies, fasting, meditation and cold water baths. Long distance running, contemporary pow wows, canoe races and wrestling, are

some examples of the social and recreational activities (Gilliland et al, 1988; Sue, 1980; Morales & Sheafor, 1987; and George, 1991).

Furthermore, in terms of cultural differences, Gilliland et al (1988) explains the structure of non-literate society or oral history. The oral literature of Native American people is an organized manner of transmitting a society's knowledge and socially acceptable behaviour. Traditionally, the instruction of Aboriginal socially acceptable behaviour and societal values occurred in an indirect, informal manner through the oratory of stories or legends that emphasized a particular lesson, such as the need for cooperation, respect or the need to avoid harmful behaviour such as greed or jealousy.

Based on the Aboriginal educational system, most First Nation citizens may be considered whole concept learners: that is, they prefer to begin with the whole (i.e. the bigger picture) and gradually progress to the details of the subjects. Learning styles, then, consist of observing a demonstration or illustrations of a model, thereby preferring the guided approach. Images, then, are required for the processes of thinking and remembering. The overall (holistic) view of the general principles incorporates intuition, coincidence, feelings, emotions and hunches.

The Aboriginal or visual learner is one who is personal, informal, spontaneous and socially-oriented who co-operates

and assists. Indian people therefore value the ability of patience and the ability to wait quietly. As such, Indian etiquette requires time for deliberation to be able to answer questions. Words are viewed as medicine, particularly in connection with a chant.

As a society, Aboriginal communities were nonliterate people. Non-literate, in this world view, means there was no written language. Important events were recorded in the memories of selected people who were trusted and respected by the people. As Penner (1983) learned in his involvement with Aboriginal people, "there were no written constitutions, history is committed to memory and recited by elders" (p. 12-13).

The Aboriginal method of chronicling was to create an oral description, in detail, of the circumstances of the event. Each orator held different levels of responsibility for maintaining history. Tribal historians held the position of responsibility of reporting accomplishments, perhaps as related to settling disputes or war. Tribal raconteurs were responsible for describing and explaining origin stories--the meaning of life as related to custom, ritual or ceremony.

For Ojibway people, the greatest compliment that can be bestowed upon a person is the word "w'daeb-wae" which translates as a close synonym for the English word "truth" but also includes confirming the speakers reliability. Literally, the Ojibway word means the speaker is right, correct,

accurate, and truthful. "W'daeb-wae" was the highest position a person could occupy in Aboriginal society while "w'geewi-animoh" which translates in English as meaning the speaker talks in circles, does not speak with truth, thereby describing the worst position a speaker could hold in the Aboriginal community (Ross, 1992). Due to the fact that Aboriginal people relied on oratory documentation for the preservation of custom, tradition and history, their health care system lacked the credibility that European people valued. Culhane-Speck (1987) reports:

> it is often the context in which medicine is practised...that determines its effectiveness...[t]his verbal method of passing on information lacked the cumulative power of the written word which, particularly in medicine, permits painstaking comparisons that results in progressively constructive diagnostic and therapeutic refinements (p. 81-82).

This research project focusing on the Tsleil-Waututh First Nation citizens involves experiences with sickness, disease, health and treatment. It observes and translates the peoples' health care experiences beginning with experiences of historical relationships within their contexts, the influence of religion, the evolution of those relationships, and the decisions that influence health care choices both past and present.

Chapter III

PROFILE OF TSLEIL-WAUTUTH (PEOPLE OF THE INLET)

At the time of this study in 1990-1991, the Burrard First Nation population totalled 198, with approximately 102 On-Reserve citizens. The On-Reserve population fluctuates due to people in transition between On and Off Reserve status, Bill C-31 members returning home, and births and deaths. Due to legislative changes regarding the legal status of Indian people, in general, there exists three possible different categories of residents On-Reserve: Original or natural members; Legal or those people who are Registered Tsleil-Waututh through marriage who are not natural citizens; and residents, that is, people who live On-Reserve because of marriage, for example.

In an attempt to acquire accurate data that reflected genuine Tsleil-Waututh nationhood, specific people were excluded from the study. Certain sectors of Legal Tsleil-Waututh people, primarily, white women who acquired Indian status by marriage; citizens who originated from other First Nations were excluded, as were non Indian residents, that is, people who reside On-Reserve because of marriage; and Off-Reserve Band members. In addition, re-instated citizens, that is, Bill C-31 citizens, were not participants of this

study because at the time of investigation they were in the process of re-establishing residency On-Reserve.

Prospective candidates of the remaining Band members were categorized according to the Life Cycle of Indian people. That is, elders (who, in this case, prefer to be called old people); adults, young adults and children.

TABLE 3

Tsleil-Waututh Study Population, January 1991.

	No. On-Reserve	Social Contact	Interviewed
Elders	12 (1 Death)	10	7
Adults	22	16	6
Youth	43	20	2
Children	14	4	0
TOTAL	91	50	15

Tsleil-Waututh in the Year 1990-1991

Tsleil-Waututh reside along the Burrard Inlet, surrounded by the neighbourhoods of North Vancouver to the west, Deep Cove to the east, the Mount Seymour Parkway to the north. To the south, the inlet itself separates the community from Vancouver. The Dollarton Highway runs through the centre of the village. The land mass that they currently occupy measures a small 265 square miles compared to their Aboriginal

land mass of the total Burrard Inlet which is their Aboriginal territory. This includes both sides of the Burrard Inlet, beginning at the headwaters of Indian River out to the west points of what is known today as Point Atkins and Jericho. During investigation, there were thirty seven occupied houses with eleven houses under construction.

There continues to be berry and fruit growth but in limited quantity and quality of what it once was. These people can no longer fish in the inlet because of environmental pollution which can be attributed largely to the oil refinery plant housed directly across the inlet. Contributing polluters are the different kinds of boats that pass through the inlet. The land itself continues to be appropriate for farming but, due to pollution created by the variety of vehicles that pass through the middle of the village, agricultural activity is restricted to gardening of flowers with limited vegetable gardens.

Hunting and fishing endeavours continue to occur among the Tsleil-Waututh. Due to the environmental pollution these activities are participated in outside of their natural territory; fishing activity is more predominant, while hunting continues to be a struggle due to lack of access to hunting territory.

The Tsleil-Waututh men are soft spoken, quiet, and radiate a calming strength. They project an aura of safety and are natural peacekeepers. The women are soft spoken with

contagious laughter that transmits their maternal tenderness. They are the strength of this community leaders in their Aboriginal world. The balance between partners can be witnessed by a special glance that announces their love, admiration and family commitment. The Tsleil-Waututh children are friendly, observant and care-free. They continue to occupy a special place in their Aboriginal world, they learn to love life by watching their parents and extended family interact. The children are confident in the love of their caregivers as they play make believe games in the puddles made by the rain, bellowing joys of laughter and giggles of pleasure.

The Catholic church located on the Reserve is a major gathering place for the community where prayer is utilized for requests for healing both physical and emotional ailments. These requests are made for both Tsleil-Waututh citizens themselves or family members and friends who reside elsewhere. The building itself is modest: white with an antique look about it. Its simplicity reminds the visitor of the value of being humble. It is a quaint structure, almost picturesque as it lays lost-looking, awkwardly placed alongside the hill. It looks abandoned, but when the Tsleil-Waututh attend Mass it becomes alive with prayer, rejoice and unity: Aboriginal Nationhood.

Prayer presents itself as a daily routine of the Tsleil-Waututh and continues to be an important element of healing in

spite of its removal from its Aboriginal position. Informants reported prayer to be adapted from Catholicism and transformed into Aboriginal form. A male adult respondent reported his interpretation of oral knowledge regarding this transformation:

> ...everything was basically of modern life time...if you were sick then you know, they used the doctors and medicines...but still then...even though they never really talked about it, in hindsight now from my childhood experience, I could see alot of Native spiritual values influencing...their faith alot. Because it was their attitude towards faith ....Taking the faith, that they had of maybe a herbal remedy...a medicine, they transferred that into the faith of you know if you ask God to take it away it will be taken away. The only place still of refuge to go, within their relationship with God even though the ritual and...the prayer may be different....cause they prayed for everything. That never changed from when they just lived according to their old customs. My uncles...lived out their faith greatly.....It wouldn't be uncommon...when they were alive to pop in to the big Church over on Vancouver you know the Cathedral, the Catholic church there. It wouldn't be uncommon if you'd drop by there at noon and find one of my uncles in there. Same with my dad, if we were in town and they were in town at noon time and they knew there was a mass there, they'd go to mass. They were always contributing to...buying of the ceremony of the mass, for loss of loved ones and family, always. Always making sacrifice for...prayers and...blessing things....So they completely transferred their...faith and their rituals over...into rituals of the church. But I think they even made it stronger in alot of ways. I think they taught the priests alot about faith....because they were so....expressive with their belief. All the time like when I was a kid....they were pulling in a canoe together...all the brothers...they'd be watching from the beach...I bet you if...you look at each and every one of their pockets...you'd find a rosary in there and you see [my brother] do that today....It wouldn't be an uncommon thing. And some of those prayers would be for us to be [successful]. Alot of them were to protect us. Keep us strong, in what we're doing.

The Tsleil-Waututh graveyard lies straddled along the Burrard Inlet with both ancient and modern markers--the home of family members who have travelled to the other side of the universe. The primary Aboriginal ceremony reported was the Burning. This ceremony is conducted for deceased citizens which provides these people with the necessary provisions to make their journey home to the Creator. Specifically, the ceremony requires the burning of the deceased persons' clothes, utensils and food for use in their original home.

The drum for this First Nation is used in its natural state, both for ceremonial song and entertainment. The pipe was not publicly utilized although it was reported that a pipe does survive in the community. The majority of Tsleil-Waututh participate in the Long House for selected ceremonies such as Name-Giving but do not participate in the four month ceremony of the Long House itself. The reason for limited participation was contributed to the decision of the Grandmother to practice Catholicism, therefore, participation in the Long House ceremony today is an individual choice.

The Tsleil-Waututh continue to share an Aboriginal relationship with the animals. The behaviour of the animals are interpreted by the Tsleil-Waututh similar to what most Canadian people would consider an omen. A male adult reports:

> Yeah, it depends on what kind of bird it is. A robin is a good sign. A sparrow is ah you know be careful. The raven we have here depends on what um how he's talking [if it] is uh good news or bad news. If he comes around singing [then] you're gonna get good news but if comes around in a real bad mood then you'll get bad news.

A second male adult reports:

> Ravens, um, carry for us, messages of death depending what kind of noises they're making and how often they come. I have a respect for everything....like, someone kills spiders,.... but I um rather than let anybody kill them I, ah, just pick them up and put them out.... Maybe, um, all the networking is important. They're very intricate in building their networks and they weave their webs....And I'd like to think that mine's the same way. So I guess that's why I do it. I talk to them all, you know....I watch things when I'm out, where I'm at, I watch for birds signs, animal signs those kind of things. Listen to the birds and see what they're saying.

Another male adult describes his knowledge of power:

> When they [whales] used to come in [the inlet] there was going to be a death of a chief, medicine person, or a powerful person. I was told that when my mom passed away, they were in the harbour here....one of the elders...said that my mom did have some power...you know, she never, ever talked to me about it....

Canoeing, continues to be an active traditional sport of this First Nation. Preparation for contest races involves rigorous physical training, change in diet and commitment on the part of participants. The structure of the canoes are a visible challenge for any sportsman. It measures approximately twenty-feet long and four-feet wide. As the visitor watches the young adults launch their canoe into the polluted water of the Inlet for practice, it becomes obvious the kind of dedication and physical strength that is required for competition. Their sense of nationhood is revealed as they wade to maintain an authentic aboriginal sport. In addition, the younger people are active in contemporary recreational activities of competitive baseball and soccer.

A second major gathering place for this community is the Band Office where community functions such as celebrations and fund raising events take place. The physical structure of the building is modern but not luxurious compared to other Canadian administrative offices. The building itself appears to be an old warehouse from the outside, however, as you enter the warehouse the atmosphere disintegrates as the aura of business engulfs the visitor.

A Canadian flag, tucked inconspicuously in the corner in front of the bathrooms, greets you. A green chalkboard is full of the Band employees' weekly schedules and advertises the next scheduled Band monthly meeting. In the middle of the reception room sits what appears to be just an ordinary stacking table but a closer look provides the visitor with an awesome, hand-painted British Columbia Indian art design, a symbol perhaps of the sun or the Medicine Wheel.

In the northern corner of the reception area is a small partitioned area, the office of the Economic Development Officer who is also a Council member. Adjacent to the reception area are two separate offices--one is the second home of Chief Leonard George and the other room is the Administrative assistant's office.

Through the middle door of the reception area, the visitor finds the meeting room of the Tsleil-Waututh. It contains stacks of chairs, an abundance of literature regarding health, diet, education programs, Indian magazines

and blackboards that this First Nation's Teacher's Aide uses for instruction of the "homework program" she has designed to assist the children in elementary school. On the walls are pictures and posters on diet, Indian role models, and the proposed economic development project of the future Band Office complex which is intended to also house a gymnasium.

This room possesses many uses including vaccination clinics arranged by the Band's Community Health Representative or commonly known to these people and most Canadian Indians as the 'CHR'. Some of the ladies in the community use this room for their aerobics class that they attend twice a week--a modern method of preventative health care practices. Feasts, celebrations, monthly Band meetings and fund raising events all occur in this room.

The offices of the Community Health Representative and the Education Co-ordinator located in one room to the west display posters on the walls regarding diabetes and breast feeding. One poster in particular catches the eye it reads: "Aids is not a whiteman's disease". On the book shelf lies a box of free condoms, for the band members. The Band social worker is located in the adjoining office next door. Her walls also contain posters targeted for the Aboriginal community. The slogans on the posters are designed to promote pride and a commitment to restoring health in the Aboriginal world by reducing alcohol and drug abuse: "Keep the circle strong".

The Researcher was aware of one birth which occurred during the time of study. With heartfelt sympathy, the researcher acknowledges the death of a female old person that occurred during the time of investigation.

There are three deaf people in the community: one elderly citizen who utilizes a hearing aid, has speech and can read lips; one teenage male communicates through the use of sign language; and one female child approximately two years old with no speech who, at the time of investigation, was beginning to attend a special program for the Deaf.

Three cases of spinal meningitis were reported during a span of thirty years with the first case reported in 1963 that resulted in death; one case resulted in deafness and the results of the third case were unknown. There were no explanations regarding cause or definition provided by respondents.

An indefinite proportion of the Tsleil-Waututh are non-smokers. Only three of the fifteen interview participants smoked cigarettes with only two people reporting themselves as avid smokers.

Chapter IV

RESEARCH DESIGN AND METHODOLOGY

Rational

The purpose of this study is to investigate the definitions of health, sickness, disease and treatment as presented by the On-Reserve original citizens of one Canadian First Nation. As a means of investigating the health status and health care practices of Indian people, culturally, an ethnographic study was selected that is intended to be exploratory in nature. An ethnography was chosen because it is known that survey questionnaires do not work with Indian people. This type of research methodology has occurred among First Nation communities repetitiously and consistently with lack of significance in terms of creating healthy and productive change in the community.

Krotz (1990) has identified the impact of the negative results of studies conducted On-Reserve in Manitoba by outsiders or non Indian people. The researcher's interpretation of the community's lifestyle portrayed Indian people as the typical cultural indigents. For example:

> Norway House believes itself to be perpetually under study, and there is ample evidence to back up this supposition. On an Indian reserve there is always somebody from the "outside" poking around: an anthropologist working on a graduate paper, a government or health department or school board official doing a

> study, a journalist....The outsiders are there either out of their own curiosity, or representing the curiosity of the organization that sent them. They either want to learn something new, or they want to gather data to support a theory, or, if they are from some branch of the government, they want to dig up some information to support either continuing, changing, or perhaps abandoning some program and some expenditure (p. 46).
>
> What the Norway House people resent most are the hit-and-run artists who arrive with a preconceived thesis, take a quick look around to grab enough data to support it, and leave, never to be seen again. They complain about and feel powerless against reporters and anthropologists who do not really want to understand them, and worse, have no affection or generosity for them" (p. 48).

In relation to the community impact of such studies one of Krotz's informants reported: "We don't like being stereotyped as a bunch of drunks" (p. 49).

Adams (1975) being of Aboriginal ancestry explains the cultural mores of the managing the intrusion of outsiders:

> ...a typical response pattern of native people who have been methodically excluded from decisions on issues affecting their lives and communities...[Aboriginal people]...have developed a peculiar kind of "accommodating language" that they use when speaking to white officials: they give...superficial answers they think will please their colonizers....They hope that these accommodating answers will make things run more smoothly in the colonized world and facilitate relationships between colonizing authorities and colonized natives. As a result answers by [Aboriginal people] to formal questionnaires rarely represent true opinions about the questions (p. 156-157).

The study population were asked questions about their feelings and experiences with episodes of sickness and disease; what types of treatment they utilized during such episodes, if any; and finally, what constituted being healthy and what practices they utilized to maintain their state of health. In addition, inquiries were made regarding the

history of their people concerning episodes of sickness and disease, the types of treatment employed by the people, and the practices that were used to maintain their state of health.

Overall Design

An ethnography may be interpreted as a qualitative research approach that seeks to describe a group or culture by focusing on explaining the daily, routine lives of people while concentrating on the patterns or processes of human thought and behaviour of the group (Fetterman, 1989). It allows respondents to describe in their own words their experiences within their own contexts which may explain to others their world view that may sometimes be cultural in nature. The researcher's "commitment is to a faithful and accurate rendition" of the participants' ways (Goetz & LeCompte, 1984, p. 224).

An ethnography is descriptive in nature; it provides for the documentation of a researcher's interpretation of multiple realities of humans from different cultures. The researcher's theoretical approach helps to define the problem and provides problem-solving direction. Fetterman (1989) describes grounded theory as the basis of a typical model for ethnographic research. Further, he contends, humans behave in ways that are based on their individual perceptions and that

behaviour has consequences. Therefore, the subjective reality each individual sees is no less real than an objectively defined and measured reality.

The ethnography was selected as an appropriate research tool because it deliberately requires the researcher to experience the lifestyle of the study population by participating in their daily interaction (participant observation). Furthermore, an ethnography requires the researcher to describe the study population's story by presenting their history, demographics, custom, tradition and the physical environment as perceived by the study population while stating/verifying the extent to which these exist.

Because of the uniqueness of any particular group of persons and the commitment to relate the people's perspective, a study such as this raises questions regarding reliability and validity.

With respect to reliability, as humans change in the process of living, no study can be replicated exactly. However, there is no doubt a non-Native does not have access to the same extent, to information as a Native researcher does and, therefore, would have different results. Discussions with Aboriginal and Caucasian researchers and Indian people state this to be the case. At this point in history, Aboriginal people will not give certain information to non-Natives.

In this study, the steps taken are described so that future researchers and participants will be able to replicate procedures to thereby determine which is similar or dissimilar in their outcomes. Non-Native researchers must be aware that the kind of questions that are traditionally asked and the research methods used will elicit guarded and sometimes mischievous responses.

In order for the reliability of this study to be evaluated, the researcher's entry and position in the community is outlined, the participants described, and the researcher's participation and observations on site are recorded. Interviews were taped and transcribed verbatim. The words of the informants are used to explain and elaborate the analysis.

The researcher is very aware and constantly alert to the importance of having her respondents frame their participation in their own context and in their own words. The open-ended framing of areas for discussion, having an observer, and moving from the transcribed data to the analytic categories, all aid in the assurance of the validity of the study.

Accessing the Setting

An exploratory ethnographic study was selected for two reasons: first, the intention of this study is to acquire the definitions of health, sickness, disease and treatment of the

Natural citizens of one First Nation to provide a general example of Aboriginal definitions, collectively. The results of which may assist social workers and other health care practitioners in their therapeutic relationships with First Nations people both On and Off Reserve.

Secondly, the ethnography was an appropriate research tool because it is known that survey questionnaires do not work with Indian people because of the lack of personal contact with respondents and the use of closed responses. Survey research methodology, as Krotz (1990) has identified, has occurred among First Nation communities repeatedly and consistently with lack of accountability or significance for First Nations citizens, in terms of creating change in or empowering the First Nation community.

Furthermore, York's (1990) informants identified the need to develop not only culturally appropriate but community specific requirements for Indian communities. For example, specialized therapy requires the development and utilization of non-traditional medical solutions. This type of treatment is required in combination with the secure development of economic stability because "the root of the [epidemic] problem, he believes, is the "social and economic upset, discord and disharmony (p. 18)".

The most neglected aspect of On-Reserve Aboriginal life, by non Indian people in regards to research is the fact that Indian Reserves in Canada occupy a different legal territory.

As Krotz (1990) has identified, the lack of recognition of Aboriginal authority and jurisdictional control reduces the First Nations Government authority to approve or disapprove the results of research conducted by outsiders. Under the Indian Act (1989), section 30: Trespass On Reserve, it is possible for non Band members to be charged with trespassing. Therefore, initial contact for this research project was made with the Tsleil-Waututh First Nation Chief, Leonard George, to discuss the feasibility of conducting this type of research On-Reserve with the Tsleil-Waututh. Permission was granted from the Chief (Appendix B) and the researcher was located in the Band office (the Administration building of most Reserves and the most public place) for two days per week for eight months and, as well was involved in community functions throughout.

Background

This research project is a catalyst in itself because of who the researcher is. I am a female, First Nation's citizen social worker. I am an Anishnabek or Ojibway citizen of the Garden River First Nation. I adhere to the cultural boundaries of my people, the Anishnabek that are defined and restrictive. I am only in my thirties and have not obtained the right to publicly discuss the details of ceremonial activities or other sacred practices with non Indian people.

I am not fluent in the Anishnabek language, my knowledge is limited to certain words, phrases or sentences. I am married to a Saskatchewan Plains Cree man and we have three children. Our practice of both the Anishnabek and Cree cultures' ceremonies, rituals and tabu ensures preservation of our societies.

I am an advocate of creating culturally appropriate social work practices and interventions for First Nations citizens therefore this research process recognized, emphasized and utilized the systems of Indian people first and manipulated research strategies to fit those systems. The importance of this study is to ask Indian people the questions concerning health care practices that have been overlooked. By providing non Indian people with a specific example of the cultural definitions of health, sickness, disease and treatment presented by one British Columbia First Nation, it is hoped that the information presented will assist in reducing the cultural gap between Canadian First Nations people and non Indian Canadian society's helping professions.

Secondly, the intention of this study is to acquire accurate data of a culturally different society that reflected their collective Tribal definitions of health, sickness, disease and treatment of the citizens of one First Nation based on the health care experiences and practices of this study population. The ethnography was selected as an appropriate research methodology because it requires the

presentation of the physical environment of the study population and the daily interaction of people. Furthermore, it requires the researcher to have physical contact with the study population as a participant observer.

The researcher initially was introduced to this First Nation by familiarizing herself with the operational structure of this community. That is, she became familiar with the Band employees who manage the programs and deliver services at the Band Level specifically the Education Co-ordinator, Community Health Representative, Economic Development Officer (also a Band Councillor), elementary School Bus driver, office janitor, the Administrative Assistant who is responsible for the daily operational functions of the office, and the Band Social Welfare Worker.

The Chief and the Band employees became primary community facilitators/key actors of the research project because they were most familiar with the researcher. In essence they became the researcher's 'telegraph' to the community. The social welfare worker became a primary source of acquiring community sanctioning because of her relationships with the community members especially, the Old people, and the relationship developed between herself and the researcher.

The researcher initially integrated into the community by volunteering to perform tasks such as answering the telephone, typing, delivering community newsletters to each house On-Reserve, making coffee at the Band office and participating in

office lunch pools. After a short period of time, approximately three weeks, employees began to request/invite the researcher to perform such tasks. In addition, her input was requested by the Band Social Welfare Worker with program planning and counselling strategies for On-Reserve Band members.

Secondary introductory community integration of the researcher involved the researcher simply sitting at the Band Office. By making herself visible to the people, she was able to visit with Band members who arrived at the Band office for scheduled appointments. During their visits, the researcher introduced herself and explained her purpose in the community to Band members who were unfamiliar, shy and awkward with her. Those community members who were familiar with the researcher engaged in conversation regarding comparison of communities, such as sharing of histories of both tribes, the effect of the Oka crisis, the Indian Act, the Department of Indian Affairs or life in general.

It is the researcher's perception that the style of conversation between the researcher and community people changed from inquiries regarding the research project to initiating conversation with humour. Inquiries regarding the progress of the interviews with the Old people that followed the humour indicated to the researcher that her relationship with the people changed from "checking her out", to trust and acceptance. As a result of this type of interaction with the

people, the researcher developed relationships with two other community members who also became part of the researcher's community "telegraph".

The researcher was involved in the Healing Circle at the request of Chief Leonard George. It was designed to assist the Tsleil-Waututh to deal with the community dynamics caused by a car accident that resulted in the death of a Band member. Intervention support services related primarily to the elements of racism and judicial injustices that were predominant because the investigation of the accident revealed that driver of the car was a tavern owner in a non Indian neighbouring community. For the Tsleil-Waututh, the delay in immediate legal results, in combination with their past experiences of lack of safety along the Dollarton Highway, and the run-off of the Oka crisis, further fuelled the community dynamics. All contributed to an increase in the community's overall frustration, anger and grief.

As a result of the contact with community people involved in the Healing Circle, the researcher engaged in unstructured, individual counselling relationships with community members during the mid and latter stages of research. Finally, as part of participant observation strategies, the researcher and her family attended potluck dinner fund raising events held On-Reserve. External to the research process, the researcher and her family received personal invitations by community

people for events such as birthday celebrations, supper, cosmetic parties and holiday celebrations.

Data Collection and Procedures

Each proposed phase of the research project was first discussed with Chief George to acquire his approval because of his responsibility as the elected leader of this community and his required accountability to the people and the researcher's interpretation and commitment of utilizing the systems of Aboriginal people. For example, in regards to consent to participate in the research project, the University's requirement to have people sign individual consent forms to participate within the research project presented a cultural conflict because the Chief, the head of First Nation (On-Reserve) government, had provided his written consent to the University of British Columbia's Faculty of Social Work to allow the research project (Appendix A) to occur On-Reserve, thereby providing the First Nation's collective consent. The Tsleil-Waututh and the researcher understood that this collective consent did not eliminate the individual's right to refuse particpation. The purpose of this collective consent provided by Chief Leonard George was an attempt to eliminate the cultural conflict by respecting the authority of the First Nation while educating a non Indian academic institution.

The academic requirement to have the participants provide their written (individual) consent to participate in the research project conflicted with their cultural mores of the Tsleil-Waututh and the researcher. Due to the sensitivity of the research project--because a study of Aboriginal health care accompanies theological based healing methods that are usually not intended for non-Indian people--and, as a means of ensuring respect and protecting Aboriginal and individual confidentiality, the Chief was kept up-to-date on the project's progress and the researcher's involvement with community people.

The researcher initiated community introductions of herself by making home visits. Two female Band members (Education Co-ordinator and another female citizen) were requested by the researcher and the Band Social Welfare worker to accompany the researcher on these preliminary home visits. This request was made by the Researcher as a means of acquiring community sanction of the research project and as a way of respecting Indian protocol. The responsibility of these community members during these home visits was to simply introduce the researcher. Specifically, her name and position within the community: a University student. The researcher's responsibility during these home visits was to explain the purpose of the research project and to emphasize participation in the study was strictly voluntary. The researcher also explained the intended process of investigation during these

visits--that is, the Old people of the community would be the first people to be interviewed followed by the adult, young adult and children sectors of the community.

In addition, inquiries by the community people regarding the identity of the researcher also occured at this time. For example, questions concerning the researcher's original place of residence, her tribe, her particular choice of study at the University of British Columbia, her marital and family status, her knowledge of Oka and her and her family's like or dislike of Vancouver were asked by community members.

Seventeen individual homes of the total thirty seven occupied houses On-Reserve were visited. The home visits varied in duration from five minutes to one hour at which time the researcher again emphasized that Tsleil-Waututh participation in the research project was strictly voluntary and because of the unwritten Indian etiquette regarding the custom of hospitality and that they were not obligated to participate. That is, one is expected to receive strangers kindly and provide them with the best of what one owns.

Upon completion of these home visits, the researcher arranged a second visit by telephone and went unaccompanied, to discuss in detail the purpose of the research project, as a means of allowing Indian etiquette to occur. That is, Indian etiquette requires time to deliberate questions that are asked. Again, the actual time of visits varied from one half

hour to three hours with arrangements being made for the actual interview.

The issue of tape recording the interview was discussed in detail. The need to tape the interview was based on the idea of providing a natural environment for the process of oral history to occur, that is, the environment where one is expected to sit, listen and learn. Therefore, recording the data by pen would have become an obtrusive element of the research project.

The ownership of the tape recording was determined during this visit. Each band member decided if the tape would be collectively or individually owned. Collective ownership refers to the tape becoming the property of the Tsleil-Waututh First Nation for the purposes of their archives. Individual ownership refers to the tape becoming the property of the person interviewed and not the Tsleil-Waututh First Nation. During these second home visits the researcher made it very clear that she was interested in studying only the health care system of the Tsleil-Waututh people, in terms of physical practices rather than theological practices. This focus was emphasized to ensure and protect the confidentiality of the sacred systems of Indian people.

Interview

The actual interview process began after the preliminary series of home visits with Band members. The purpose of the research project was again re-iterated. During two of the actual interviews with the Old people, the Band Social Welfare Worker accompanied the researcher. Her attendance during these interviews occurred as a means of Aboriginal witnessing and because of these people's past negative experiences with social workers. Furthermore, the Band Social Welfare Worker held the unwritten community responsibility for the researcher's activities On-Reserve. That is, she became responsible and accountable to the people, in the sense of knowing who the researcher was, her purpose in the community, and her rationale for conducting the research, particularly the exclusion of certain people.

The actual interview ranged in duration from two hours to four hours. Prior to engagement in the interview, a gift was presented to each informant as part of Aboriginal etiquette. These gifts consisted of house plants, baseball caps, scarves, wild rice and other food (e.g. doughnuts, cookies, home cooked meals/food prepared by the researcher), jewellery and books.

Culturally, old people or elders within Indian communities are the source of knowledge and authority who hold the unwritten responsibility of sanctioning a particular event. By simply participating in the interview process they

provided their consent for community participation in the research project. Due to this required cultural sanctioning, the interviews began with the Old people and did not proceed to any of the two remaining groups until interviews with the Old people were complete, as a way of maintaining cultural appropriateness. Selection of candidates for this study is, therefore, purposeful to attain cultural appropriateness and representatiton from the three age groups.

The Respondents

Seven Old people were formally interviewed: three married couples and one bachelor. The Band Social Welfare worker accompanied the researcher during the interviews with the bachelor and one couple. One couple was not interviewed due to the health status of the spouse, who was recovering from open heart surgery and was suffering from depression as reported by the spouse.

Six Adults were formally interviewed of which three were males and three were females. Two males and two females were interviewed individually; with one married couple interviewed together. Of these six informants, the data that the three females provided were excluded from the results because it was discovered that they were not natural Tsleil-Waututh citizens.

A second married couple declined from the interview process due to the jeopardy that the interview would place

both the researcher and respondents. Both the researcher and the respondents agreed there exists a risky fine line between participant observation and inter-tribal sharing. Inter-tribal sharing for these particular respondents presented a risk factor from an Aboriginal perspective because of the category of treatment that would result in discussion regarding Aboriginal ceremonies. Therefore, confidentiality became too great a risk for both the respondents and the researcher who together decided not to conduct an interview. This is not to say that the research project was not supported by this couple, it was merely a method of protecting sacred Aboriginal information for both the respondents and the researcher.

Two young adult female respondents were individually formally interviewed. Due to training for canoe races, employment and sports activities, this sector was the most difficult to interview formally. In addition, most of this sector were young married people with children who also kept their parents schedules occupied. The children as well were difficult to contact due to their own busy schedules of school, sports and accompanying their parents on their activities.

An additional, seven people were involved in the Healing Circle which the researcher participated in. Her role there varied from leader to co-leader to observer, depending on the situation. The remaining thirty-three people were informally

interviewed when they visited at the Band Office while waiting for their appointments, when they met with the researcher while walking around the village, or when the researcher attended fund raising events held at the Band office or functions recieved by personal invitations.

Problems in Sampling

The minor problem in sampling was the exclusion of citizens of this First Nation. Although the exclusion of certain members was necessary for an accurate representation of findings that were truly Tsleil-Waututh, the exclusion of certain members did create limited objection from some Tsleil-Waututh First Nation citizens. This objection placed the research project in a position of jeopardy which the Old people of this community were asked by the researcher and the Band Social Welfare Worker to resolve. The Old people provided the researcher with their permission to proceed with interviewing only Natural Tsleil-Waututh members.

In combination with this obstacle was the difficulty of explaining and labelling Aboriginal protocol or what has now been labelled the internal process for data collection On-Reserve to the University. One example of this difficulty was the process of witnessing that requires a community member to be present during the interview process. Ponting (1986) experienced the internal process for data gathering during his

case study of the Kahnawake First Nation in 1985 and attempts to describe this process in Institution-Building in an Indian Community: A Case Study of Kahnawake (Caughnawaga).

In this particular case, the Band Social Welfare Worker was present during two of the interviews to assist the researcher with establishing her credibility within the community (by word of mouth) and to assist the Researcher with the arrangements of the preliminary series of visits (matching the Researcher with the two community members) to each home On-Reserve. Further, she was critical in explaining why this stranger was in the community, operating specifically out of their Administrative (Band) office.

The second obstacle in sampling was determining which of the adult and young adult sectors citizens were On-Reserve, Off-Reserve and who was in transition. With the assistance of the Band employees and utilizing the Band List, possible research participants were categorized into their appropriate age group of the Life Cycle (i.e. Medicine Wheel).

The Band List is a legal document that originates from the Department of Indian Affairs Registrar's Office in Hull, Quebec. Its purpose is to verify entitlement for registration of Indian status under the Indian Act. This registration is subject to particular sections of the Indian Act and the Band membership code of the Registry group (First Nation). The rationale explains which category an individual is entitled to: Status or membership.

Utilizing the Band List and arranging possible respondents into their appropriate age category the next task was to determine who was a natural Tsleil-Waututh citizen in collaboration with the Band employees: Education Co-ordinator, Social Welfare Worker, Community Health Representative, Economic Development Officer and the Administrative Assistant. Finally it was determined that there were ninety-one (91) possible interview candidates.

The third obstacle in sampling, from the research perspective, was the length of time required to adhere to the internal process of data collection, that is, the series of preliminary visits and the restriction of remaining with one sector until all informants of that sector were interviewed.

This obstacle was further complicated with the problems of providing translation between what functions as Indian protocol and what was required academically by the University itself. For example, in terms of providing categories of respondents, an academic requirement was detailing how an elder is defined an elder, specifically what qualities are required to be an elder. For the community people, especially the old people themselves, they preferred not to be referred to as elders because of the external mystical connotation of what an elder is expected to be: a healer/medicine person.

The responsibility for defining who was what (e.g. elder/old person, adult, young adult) was decided by two of the Old people of this community (one male and one female)

with the assistance of the Band Social Welfare Worker, as requested by the researcher. They decided then that age 65 and above would constitute an old person, age 30 and above would constitute an adult, below age 30 to 21 would constitute young adult, and under 21 would constitute a child for the purposes of this research endeavour. These ages were selected for two reasons: the age was a close approximation of the Aboriginal age, but primarily because it was guestimated that the ages would be similar enough to be acceptable within Euro-Canadian society, primarily University requirements.

The first intention of the research project was to create change not only in terms of the profession of the social work relationship and Indian people but with the processes of research and its relationship with Indian people. More importantly to ensure that the research project was "Indian" and community owned.

Problems in Data Colleciton

In terms of data collection the first major problem was ensuring that the people reached a level of trust with the researcher so that ceremonial aspects to healing would not be violated. The level of trust was acquired through the process of inter-tribal sanctioning. That is, through the exchange of sharing ceremonial knowledge, the researcher was able to demonstrate her commitment to maintaining Aboriginal privacy.

In addition, through her relationships with different Tsleil-Waututh citizens she was able to build and maintain a trust relationship with the people on an individual basis.

The second major obstacle to data collection were health problems that respondents were experiencing at the time of study. A flu virus was active in the community, and people had surgery, medical and dental appointments. There were funerals that necessitated no intrusion from the research project for days at a time which accumulated into weeks throughout the research project. There were minor obstacles like headaches, toothaches, batteries for a hearing aid, unexpected visits of respondents family and friends, and a level of shyness, especially with the young adult sector.

In addition, for the young adult sector it was the season of training for canoe racing, baseball practice and games as part of these young adults' recreational activities. As well, these young parents were involved in taking their children to baseball and soccer games. Life itself, including employment activities, grocery shopping, fund raising and church activities all contributed to the difficulty in arranging an interview date. Most ironically, however, for those citizens who participated in the interview process, forgetting about the tape itself when interviewing was problematic. Specifically, because of the level of comfort within the interview process the need to change the tape to record the data was sometimes neglected.

Finally, it became apparent during the interview process, that language itself was a problematic variable. The style of the interview itself was designed to be as comfortable, familiar and unobtrusive as research itself allows. As expected with ethnographic inquiry the style of conversation within the interview became a visit rather than a research interview, per se. A problem with this relaxed format was the respondents' disorder being labelled a disease by the researcher during the conversation which prompted the respondent to re-label their unhealthy condition a disease. This problem was corrected by the Researcher by paraphrasing what was previously stated by the respondent and by the Researcher reinforcing that she was interested in their personal definitions, with apologies made for the confusion created by the Researcher.

Data Analysis

The data of the Tsleil-Waututh was transcribed (verbatim) and analyzed following the order of Interviewing (i.e. Old People, Adults and Young Adults). The data represents three generations of focused life histories. The series of preliminary home visits, in fact, prepared the respondents for the actual interview. The visits served the purpose of focusing the respondents to discuss their definitions of health, sickness, disease and treatment as well as allowing

Indian etiquette to occur. The data was analyzed first to present the key events of the respondents lives and illustrate the interaction of the people within this culture over a period of approximately eighty years.

Secondary analysis of the data is the presentation of the definitions of health, sickness, disease and treatment within the context of experiences of these generations of this First Nation. This occured to present the changes of peoples patterns of lifestyles as related to their definitions of health, sickness, disease and treatment. During this stage of analysis several themes emerged surrounding the categories of health, sickness, disease and treatment such as diet and in particular, changes in patterns of lifestyles in terms of key events of their focused life histories as related to their definitions of health, sickness, disease and treatment.

The dimensions of their definitions of health, sickness, disease and treatment were analyzed to explore these generations' experiences. Were the experiences of the Old people the same or different from the Adults and Young adults? If so, what influenced the difference? This was the question used to the explore the dimensions.

The researcher developed the category "unhealthy condition" as a generic label to assist in the explanation of the respondents' states of sickness and health. The findings are presented to illustrate their story beginning with their original states of health, sickness, disease and treatment, as

preserved within their oral history and maintained by the Old people, and changes to these as they evolve over time as experienced by the respondents. The respondents in this ethnography are the descendants of the last known healer of this First Nation. All respondents are relatives either by blood, marriage or shared relationships such as godparents and godchildren.

Chapter V

TSLEIL-WAUTUTH WITHIN A HISTORICAL CONTEXT

This oratory is a collaboration of the respondents' knowledge of their history. The Burrard First Nation's true name is Tsleil-Waututh which translates in English as "The People of the Inlet". Originally, this semi-nomadic hunting and gathering society resided and migrated along the Indian Arm Inlet with the seasons. Their diet consisted of land game: moose, deer and bear; a variety of fish species: clams, salmon and mussel; and a assortment of vegetation such as apples, berries and in particular swellpitch, a type of wild onion. Their family systems were based on Clans of which hierarchy was predominant.

Traditionally, they utilized a hereditary chieftainship government system until approximately the early 1900's when the Election system of the Indian Act replaced their Aboriginal government: the owner of colonization. This First Nation does not possess an Indian Treaty. They are recognized, legally, as Status Indians under the Indian Act which designates the externally controlled, internal operational government procedures, as is the case for other First Nations in Canada.

The Tsleil-Waututh have evolved to be externally recognized as a Coast Salish First Nation who are continually

confused as belonging to the Squamish First Nation. However, the Tsleil-Waututh First Nation has always functioned as a separate First Nation with a different language: Tsleil-Waututh. Their language eventually began to be replaced by the Squamish dialect because of the marriages between Tsleil-Waututh men to Squamish women. As a result the mothers began to teach the children the Squamish language. The Tsleil-Waututh and the Squamish First Nations are both speakers of the Halkomelem linguistic group. Both the Tsleil-Waututh and Squamish languages are not fluently articulated among these people. This means that people know, understand, and speak words or phrases but are unable to engage in a strictly Aboriginal conversation. However, conventional custom and tradition has continued to be Tsleil-Waututh and it is with this sense of nationhood that these people function on a day-to-day basis.

According to Hill Tout (1978), a renown anthropologist who studied different First Nations both in Canada and the United States, the Burrard Inlet was not originally true Squamish. Most significantly, the Tsleil-Waututh First Nation apparently escaped being studied by early European explorers, anthropologist or ethnographers: "This Burrard tribe has made practically no appearance in recorded history....but it makes

sense that there would be a fiord people in Indian Arm" (1978, p. 11).

The original Tsleil-Waututh health care system included practitioners (medicine people), institutions (the Long house, cold water baths), pharmaceuticals (herbs and roots) with ceremonies offering prayer to the Creator being the fundamental element of healing.

The female old person reported:

> But you know in medicine and before anyone came here the Native people had their own you know Great Spirit. They prayed in their own way, to use English words, you know. They didn't call him the English names that we were taught after that....Hardly any sicknesses or illnesses in the olden days. There was a lot of snow, there was a lot of water, the summers were hot, we had alot of fruit, and then ah we were talking about medicines that they used. His mother used, for I would say, simple things like a boil or carbuncle or a cut, sore eyes, sore ears, toothache, which was very seldom.
> But here in the olden days they had cedar boughs to lie on, cedar bark for the babies, cedar strips from the roots for the babies basket....And I remember them telling me that they used moss [for diapers]. They buried everything that they didn't use, you know. The food, the shells, the outhouse was always there and that was just a little house--a place to bury it. Same with some of the people the older people I heard, older than me---myself, didn't like the idea of indoor [plumbing].
> So um and then we lived on all those berries. But you couldn't live on it after because a young man came along and he says I wouldn't eat those berries if I were you he says because this road is sprayed with insecticides. So the little shoots of the salmon berries we couldn't pick anymore. Because they went along with their spray along both sides. Then I think we're the only ones on this reserve that have the salmon berry shouts come up cause we have oh close to seven berry trees there.
> My grandfather died when he was ninety five and he had all his teeth, they weren't all nice looking you know but they were his own. So ah in those older times and they still used their own medicines like, well, not only that they used to live with no floors, eh. Just dirt floors....and keep it nice....And the boughs and everything was cedar: cedar boughs, cedar bark,

> everything (with emphasis) was made of cedar. This is what the Indians did. Now today, they'll come along and say well you're allergic to cedar. A lot of my brothers were told that because they worked in the cedar mill.

A male old person reports:

> It's strange but my people never did talk about any. Probably colds, never seen a toothache. Why I know is....I, was one of the people that dug my grandfather up....he had all his teeth. Might be one missing back here...the bones were solid and he had been in there for years. No, it's ah just normal human being, ah, like we talk about baby diseases, naturally.

The element of power continues to be an active ingredient of healing both in the use of pharmaceuticals and cultural mores. A female old person provided examples of everyday human interactions that Tsleil-Waututh utilized:

> ....that's how they expressed their feelings was your hand-touch: touch the shoulder. That expressed a lot. It was a healing....that was another healing that was considered medicine. The touching....the arm not a hug just your arm, a hand on the shoulder you know....to heal the hurt....now this is way, way, way, back before we were, you know, before even the missionaries came, that they used this way.
>
> Sharing is a healing way. Sharing your joys, share your sorrows. Actually you can relate to someone that's feeling sorrow you know because in Indian culture that's common, always very compassionate people. But that's been maybe how you'd say how I got along in my life. But all these little healing things you could almost name them from a day to day life.
>
> Same with ah little children and their grandparents you know. Nowadays, they bring in this abuse! And it's not among the Native people you know, you always, I travelled all over with my grand[parents] even though my grandmother [did not want me to travel with them] [because] I used to get seasick.

Similarly a male old person reported his interpretation of the use of power:

> I mean there's power in sharing like our circle, eh? If you feel sick, lonesome, down, tired, any kind of these feelings I would say you draw strength from this [circle]. One healing spiritual leader said you can help heal each other over the phone or a long distance away use your healing power for your friend. I believe this.

The pharmaceuticals reported by respondents possess the Aboriginal product required for the successful treatment of unhealthy conditions: power. A male old person reports:

> ...bark has the healing power to ah heal things like cuts....You masticate it. It's strange Indian people would use their saliva when other technologies would say that is ah a disease or it has microbes...but they'd use that. Put it right where the cut is....

Similarly, an adult male reports his version of power and medicine: "...you eat the roots and that's the power in the medicine."

A second male adult informant reports: "Some medicine men had a healing stick. A medicine stick they called it....They'd have a ceremony....and then use the stick with um Indian power on it".

Tsleil-Waututh health care system evolved to consist of Aboriginal pharmaceutical treatment with the absence of inherent religious ceremony, tabu or ritual. The pharmaceuticals derived from their natural environment when the conditions remained in their organic state: pure and clean. The earth's plants and trees, specifically the leaves, roots, bark or sap incorporated objects from their environment as instruments to administer medication such as clam shells. The pharmaceuticals were gathered, prepared and most often

applied by the sick person themselves. Composition of the pharmaceuticals for treatment was dispensed in the form of tea, salve, disinfectant or poultice.

A married couple from the Old People sector reported a method used for healing carbuncle based on an experience he participated in:

> carbuncle is ah a boil which is really infected, you know. Mother told us go and get some clam shells, big ones. ....break the bark blisters the [medicine] will drop into your clam shell....mother heated it up put it right on the carbuncles....and just in a while they're healed.

Other medicine utilized by the Tsleil-Waututh included treatment for digestive problems. A male old person reports his experience with this particular pharmaceutical: "when I was talking about diarrhea I wasn't just joking there is a medicine for it....Just get the roots of these...berries....boil them up like tea and you drink it....".

He provides alternative uses of this medicine as treatment for internal bleeding: "....Again you use the roots....it's boiled up like tea....And ah it's good for people with bleeding internally, ulcers, and ah mother told me different times it was also used for ah female problems".

For conditions causing respiratory maladies the use of bark was reported as a pharmaceutical by a female Old person: "and same for respiratory ailments...which could have been changed to tuberculosis but they didn't know that word;...that

something's wrong here in your respiratory area. So they used ah they chewed...bark?

Urine, was used as treatment for cuts and bee stings. A female old person reports: "Use the urine, you know that's antiseptic. Tell you, that was, that one was used for the poison".

Further, its application was also reported for the treatment of tuberculosis. A male old person provides this information: "If you got tb and very seldom, very few that ever got tb....the medicine for it was the urine of a person. You'd drink....urine of a [healthy] person... ".

Certain weeds were used for the treatment of unhealthy eye conditions. A female Old person reports: "And then there's the weeds...and the eye....[soak the weed] in hot water and lay it on the eye".

For the treatment of sinusitis the use of a root that was boiled to disinfect the air. She continues:"it would give off kind of a peppery [smell]....all the time they would have that boiling on the stove---vaporizer....not only that it was like a cleanser, disinfectant".

An Old person couple reports:

Mrs: You don't see that [medicine] around here anymore, growing, used to be lots up the back. I don't know cause I haven't seen or heard of it being up here anymore. I guess it has to do with a lot of pollution going around. Yeah.

Mr: used to be lots....

With respect to the practice of Aboriginal pharmaceuticals there exists a subtle curiosity. The absence of inherent ritual, tabu or ceremony appears to remove Aboriginal pharmaceuticals from its context of medicinal

treatment. This is significant among the adult and young adult sectors but is also evident with the old people. With the exception of one married old person couple, when questioned of their use of Indian medicine, informants reported no utilization while in fact, they presently or previously have utilized one or more Aboriginal pharmaceuticals.

A male old person explains:

> Sometimes I believe I should look [for Indian medicine] but....well I never had much to do with native healing. See I come from the generation where we had to forget about our traditions and ah see I believe in it still....Like, we, from my mom and my dad we lost the ways of our own people of healing and yet mom and dad had to use some of the home remedies that they knew. I wouldn't say so much the Indian medicine, like the Indian ways.....like we used to boil that [root] like you know when you boil VICKS and let it steam and then you breathe it for colds....As a young lad I did....

A male adult informant's story of being instructed in the use of one pharmaceutical best illustrates this process. During his recollection he becomes cognizant of his knowledge and practice of aboriginal pharmaceuticals. More importantly, this informant provides an explanation for the position of inherent pharmaceuticals within contemporary day:

> There is a [name] that we use for ah stomach problems, gas....And that helps that really does work. That's the only one other than [root] for diarrhoea. [bark] for um constipation. That's about it. I've never ever did that [root] I hear you know, heard how it should be done but I've never did it. Oh yes, we've used that [medicine]. *It comes so natural just slipped my mind*. But we do use it for infection.

A female young person describes her knowledge, experience and use of aboriginal pharmaceuticals:

> Whenever we've been sick you know I've never thought of home remedies or tried to find a traditional way of healing things. Once when I was really sick....my uncle brought us some [medicine]....it has to do with...trying to clean you out. I guess it must have something to do with the bronchial, chest, you know clean out the stuff in there....my dad's told me about the [name] bark.....But that cleans out your system because my grandpa used to you know have a dose of it or whatever I guess before training for canoes. It would just clean out your system. And my mother-in-law told me about something called [name] and I don't even know if I'm saying it right, but that was a type of medicine you would use for your stomach....

Healing Power

Every Tsleil-Waututh possess internal healing power. There is a Tsleil-Waututh aboriginal word that the people use to describe this power but is excluded from this document for the purposes of inter-tribal respect and to avoid bastardizing the language. Essentially, the word is used to describe an entity, an object, a feeling or a situation depending on the context which determines the interpretation of the word. Simply translated for non Indian people it means the power to heal oneself by the spirit within. It is essential for people to function on a daily basis as good human beings and for the maintenance of good health.

This power within is described by respondents as natural with no superstition attached to its possession. It is not questioned but merely accepted with other wonders of nature such as how the body itself heals. There is no need to examine the process or to seek its origin. It is simply

there, in everyone, in an active, present, immemorial state; it cannot be conquered. A male old person explains this power:

> Well you've heard of religious people talk about a soul. Indian people would say [Indian word] there is something inside you that you must keep strong....We know about spirits, you know. There are certain powers that spirits have. That, we know! We don't only know, we feel eh? And, ah, well I've heard other people talk about [Indian word] there's something inside you, there are people like that.

An adult male describes his sense of this power:

> That's what our [Indian word] is for like ah dance of the spirit is for the release of everything subconsciously and then emotionally. Songs and dances are made for that....I do have some power, you know. Like um, I'd never say that I was a holy person or a medicine man....I think that everybody has to a certain extent, their power.

Prayer

Aboriginal prayer, which was inherent to healing because it provided the formation of ritual and tabu intrinsic to ceremonial cure, was advocated as paganism by the missionaries. As a result, Catholicism replaced the inherent religious component of life for these people. A male old person who suffers from colitis and gout reported prayer to be a fundamental element of healing: "I pray every night. Yeah, pray for strength to endure my sickness".

The female old person who was sent to the sanitorium for the treatment of tuberculosis disclosed her use of prayer: "I'll tell you one thing is prayers. All of my friends, yep.

It seemed to you know put everything into---but that's how I know. I know I was doing that I'd get so lonely in the hospital you know '42 was my rosary".

A male old person couple explains:

> ....when my brother-in-law was really ill...before he had his heart operation we prayed alot for him. This is within our religion eh the church. And I believe if you ask for God's healing and *we know now too that it doesn't matter how you ask as long as you ask*....in the early bible it says that he created everything...so why not say creator....we were told that there's alot of power in the prayer of a child...the Archbishop in Vancouver wanted to take the Oblaque Priests from St. Paul's....all our natives went on the warpath of course, we want to keep our Oblaque fathers, [the] children prayed for this....our children....marched down to the church and pray that we could keep our Oblaque fathers....our leaders said that if you...take your Oblate fathers out....then we would have to tell our children that our Almighty God don't listen to your prayers anyways so why pray?

A male adult related his experience of prayer used for healing that was provided for the treatment of rheumatic fever:

> ....my legs used to ache from my hips down...we still continued with some of the herbs but I don't remember anything being specific....for the aching....As a matter of fact I remember that being kind of like the end....they did what the Catholic priests call a novena. And I remember that very distinctly, from when I was young. Every night my brother and sisters and my mom and my dad would be gathered around me and pray....now that I think back on it, it was *my first, ah, introduction to...to healing*. Because it wasn't long after that period...everything got better. And I knew I was better.

Another male adult reports his interpretation of the significance of prayer:

> Prayer is really important to us....our Reserve is so small and when we pray for something special in church it seems like it is answered right away...almost instantly....that's what....my family believes in right

> now. I guess....we all do that....So that's really important, it's a spiritual part of our lives is really important to us....Now it's gettin' more and more [that] they're combining both. The Native ceremonies and the Catholic ceremonies or wherever you're from. And it seems to be more...powerful for the people...

The last known Tsleil-Waututh healer was a grandmother who deteriorated her rosary in prayer in a request to have God remove her power. A male adult reported:

> ...what had happened is....the grandmother who....was a holy woman, who had the medicine, her and her husband, the grandfather, like they went through turmoil in deciding whether they should give up their way or not. Because of you know, it's like giving up everything that they know. But when she finally made that decision she did become a Catholic but the way the Catholics were like you know, you um, everything that we did had no credibility because it was all pertaining to um paganism. You know devil's work and stuff like that.
>
> And um so my dad said that she, they all attested to the fact that she literally wore out, literally wore out rosary beads, praying for her power to be taken away. And because my dad and them were um strapped and punished and chastised and everything for speaking their language in boarding schools, they naturally weren't going to pass any of their teachings on...to their children. Because why give them something that they're going to be punished for?....they had made a decision to put aside all of...their ways, and um and become who they weren't.
>
> But they did use...holy water, as ointments from the church like. I guess in the same fashion that they would have used some um herbal remedies.

Disease

It is guestimated by the Old people that Tsleil-Waututh moved from the upper point of the Indian Arm Inlet during the late 1700's or early 1800's. A definite numerical time as most Canadian people are accustomed to could not be identified

because of the Aboriginal manner of determining the concept of time. As such, these people do not identify time numerically but rather according to relatives. For example "an event occurred during my grandfather's time when he was young". The Tsleil-Waututh then settled in an area along the Inlet which has now become known as Bel Carres. The reason for this transition is unknown other than this place was originally a summer camp.

During this transition the community was assaulted by two separate incidents of foreign epidemics: Black Plague followed by Smallpox. These diseases were the cause for further migration to their present location along the Burrard Inlet. One male Old person reported the effects of the Black Plague epidemic: "there was lots of us just like mosquitos. Then the Black Plague came and we just turned black and dropped like flies."

A second male Old person reported his comprehension of the origin of the disease:

> But in those years ah I don't know if it was the 1400's or 1500's it was the Black Plague in England. And I guess it eventually got here on the ships. It's, ah, this part of the country, this time it went into quite, a few thousand people got this and it wiped them out, that's why---they just died like flies.

A female Old person reports her knowledge regarding the origin of the disease:

> Came on the ships though. My grandfather said that. My grandfather on my mother's side was a Nahanee and his grandfather came on the sailing ship and they were on the Squamish Lake. So he was telling us about that. He says the Indian people were really healthy people, strong and

> then comes this disease he says. But it, I don't know if it went any else farther than this inlet you know or where the ships could dock.

A female young adult reports her oral knowledge:

> ooh, well I don't know how long ago it was but my grandfather calls it, calls it the Black Plague. Because we used to number in the hundreds of thousands along the Inlet and then something happened and then just a handful of people were left. And like obviously I guess that was after contact with them. There were only squalls left. Well that's how I know we got down to such a small number that we are.

In regards to the small pox epidemic that infected this First Nation a female Old person reported: "But I did ask my mother you know---my father's, well, face was marked and she was telling me that, that family was hit hard. Two of the brothers had small pox. Which they didn't know".

A male adult reports his oral knowledge of European disease:

> The very first one I ever remember hearing about was um small pox. And that's when they came inland in the sailing ships and ah passed out the blankets to our people in the Inlet here. And just totally wiped them right out. That's the very first one I can ever remember hearing about. And being so devastating, I guess, to our people.

A second male adult reported his oral history regarding European disease: "small pox....the blanket of death they called it. And how it took pretty well our whole tribe. Killed them off. I hear stories of our tribe being sixty thousand strong at one time and here we are a Reserve just two hundred".

With the arrival of the European missionaries, specifically, the Oblate fathers, during the early 1800's, combined with the run-off of the Black Plague and Small pox epidemics, the natural health care system of these people began to change.

In combination with the changes in the Aboriginal religious and healing institutions that the missionaries were advocating, the Indian Act elevated this process legislatively during the late 1800's and the early 1900's. As Drake-Terry (1989) has documented, Indian ceremonies in British Columbia were legally prohibited under the Indian Act in 1885. The process of colonization for the Tsleil-Waututh First Nation began with the change from traditional government structure to the government structure of the Indian Act. The role of the Indian agent can be defined as an administrator whose responsibilities included the delivery of services contained in the Indian Act. However, the role of the Indian Agent became an Overseer who also possessed the power to legally coerce First Nations citizens to receive medical treatment.

Under section 72, Regulations of the Indian Act of 1951, subsection (1) the Minister of Indian Affairs could legally implement a Health Order in Council which gave him the power to quarantine people during time of epidemics to prevent the spread of infectious disease or to enforce the policy of quarantine by institutionalizing people in sanatoriums. The Governor in Council had the authority to:

(f) to prevent, mitigate and control the spread of diseases on reserves, whether or not the diseases are infectious or communicable;

(g) to provide medical treatment and health services for Indians;

(h) to provide compulsory hospitalization and treatment for infectious diseases among Indians, (Venne 1981 p. 337)".

Dichotomy of Disease

The introduction of foreign diseases has created a crevice of disease(s) among Tsleil-Waututh that is absorbed by two meshed categories. The first category is related to the ownership of disease. Ownership, refers to the origin of the disease. The difference between both diseases is the effect caused by the intentional infestation of smallpox through European trade goods.

A male old person describes this phenomenon:

> ....some people refer to the Hudson's Bay blanket, now, and again. It was, ah, mentioned some disease were spread with this blanket, you see. I don't know whether it happened out in the Eastern part too...they couldn't treat it [small pox] they didn't know what it was....talking about tuberculosis....in the earlier days the Hudson Bay was the company that ah according to what I hear there was some disease...was in the blanket you know. Of which tuberculosis could have been included.
>
> Again, ah as I mentioned one time in our conversation [was done]...to...annihilate the Native people....In British Columbia the population got down to 15,000...I ah

> don't know the exact day but it was in the 1900 and 14 or 15.
>
> So, in those days, there were no such things as toothache and sicknesses, cripples....like, I say though it's the change, of, like, an example I mentioned, organic gardening....the diet is that serious, it affects our system....it was the natural diet....[tuberculosis] that disease it could have been planted it's ah kind of bad to do that to your fellow human being but....it was their way of living, the diet must have had a lot to do with it. They ate the most natural things, people eat ah wild rice eh, among the Indian people out here there was the vegetation. What you call swellpitch it looked like an onion....They had something like you talk about rice up in the mouth of the river up in the end of Indian Arm here you call [name], it looked like rice too. Boil it the same....probably depleted now here. But it was there.
>
> That's why I say sicknesses are different today. It's ah the diet....you heard of organic gardening?....Nobody used to be natural, you know. Everything has changed.

During this conversation with these married old people, it was asked what types of treatment Indian people would have used for the foreign diseases, they continue:

> Mr:....in most cases just run it's course.
>
> Mrs: Two of the brothers had small pox. Which they didn't know....so my greatgrandmother...took one boy away, which was my father. And, she said, that's all they did, was to keep him warm, kept bathing him in cool water to keep the fever down.
>
> Mr:....no it was a rare disease among [Indian people], you take cancer. There never was cancer in this country. Now it's running, Indian people never did have....my sister had a type of cancer. They claimed she was one of the first Native people to contact that.

In a conversation with a male adult regarding the disease, smallpox, he states: "...alot of my ancestors that disappeared because of whiteman's disease. A lot of those things were never ever a part of us".

A male Old person informant reported: "they didn't know what it was. It was foreign, something foreign".

The second category of the dichotomy of disease encompasses what is normal, acceptable or expected. Basically, these normal unhealthy conditions are exclusively, childhood diseases. The informants did not possess an explanation of the origin of these diseases other than change in diet and environment. The Old People and Adult informants discuss their experiences of childhood diseases that occurred while residing at Residential School. A female old person explains:

> We were in boarding school when we got chicken pox. [the nuns] couldn't do anything they said just don't scratch that's all they told us and asked if we needed our fingernails clipped. Especially in those days, used to be normal, so don't scratch cause it will leave a mark.

She and her husband reported the different type of care he received at home during his experience with a childhood disease. However, diet continues to be a fundamental variable to experiences of unhealthy conditions:

> Mr: I was fourteen then.
>
> Mrs: [his father] took him to the show [he ate] ice cream, grapes, maybe anything he asked for. And then...next day, she says he's sick. And, ...the, second day then all these red things come. In those days, they

put dark blankets on the windows eh. So your eyes wouldn't be affected by the light if you had the measles.
Mr: yeah, those are normal...chicken pox, measles. It's like, ah what they call....shingles, is ah, actually reverts backs to your childhood ailments, chicken pox and measles. And if you're healed over too quick it will eventually come out in your older age....yeah it's carried over from your baby sickness. And it remained in the body all that time and it just became activated again.
Mrs: We were shocked! We'd never heard of such a thing! And it's a nerve that just runs from here to the back all along here and it's very painful. We all had the chicken pox.
Mr: didn't run it's course...healed too quick.
Mrs: well you were in school when you had the chicken pox. So was I and your mother used to tell me that when the kids had either measles or chicken pox she's put them in warm water and then it will bring it all out and when you'd see the red coming then you'd know it's measles....and same with chicken pox.

Current Health Status

Death by accidents was reported to have occurred approximately three times during the last thirty years among

these people, with the most recent tragedy occurring in September 1990 resulting in a community experienced death. During the time of investigation causes of unnatural death reported by respondents during the last thirty years were unexplained infant deaths, suicide, accidental and unusual disease-related death. During an interview with a married Old person couple they reported their experience with infant and death caused by accident:

> Mrs:...just one boy, I guess he would be twenty-nine now....he lived for eight weeks he had problems with his stomach so they operated on him. But it haemorrhaged and he died.
>
> Mr: yeah he just lived four or five days. The youngest girl died of meningitis, seven months old.
>
> Mr:....she's behind the oldest son, she's killed in a car accident when she was twenty-three."
>
> Mrs: she had a three year old daughter and was killed with her too.
>
> Mr: that was very difficult for me, she was the one closest to me. Nineteen years ago....

Another female old person reports:

> I had a lot of hardships, I lost many babies: four. And when I had another mother who had a baby same time as mine, it would really hurt. My child could be that, maybe could even look like her, cause my auntie had her babies same time as I was.

A male adult informant provides this information "....our second, he died. Crib death at six months"

A male adult reported his knowledge of the causes of death:

> Well we've lost a couple of our members in car accidents. Just on the [Dollarton] highway here. One around 1965 and

> not quite sure of the date, I lost one of my cousins she was hit by a car by the graveyard and was killed instantly. And then just recently my friend....

Suicide is an additional contemporary unhealthy condition and is reported to have occurred under the conditions of stress/depression which were alcohol or drug abuse related. Respondents reported three suicides that occurred within the last fifteen years: one female in her late thirties and two teenage males.

A male informant explains:

> As far as poisonings go: no. Ah house fires none....My cousin...shot himself must be 1981....And my [other] cousin died of an overdose not too long ago....Oh, yes [there was a death caused by] overdosed took a bunch of pills and killed herself....later 70's that's about it. My cousin [name] was depressed. That's the reason why he took his life. And I guess the same thing with [name] she took her life because of her um [marital problems] and whatever. They were linked around the disease of alcohol too. Not being able to cope with things, the reality of it where booze comes in and that depresses you further. It's never the answer. It's never the answer to fix things.

Alcohol Addiction

The unhealthy condition of alcohol addiction has been among the Tsleil-Waututh for at least three generations while treatment has been present for at least twenty years. Drug addiction appears to be a recent health crisis phenomenon. These people reported the dynamics of their struggle with combating this alcohol-related unhealthy condition. It is a struggle that changes in terms of definition from generation to generation. Death appears to be a point of struggle among

these people to return to the use of the alcohol crutch. A male old person explains his experience with the unhealthy condition of alcohol addiction:

> I just got on the [AA] program and I wanted to drink again [after the accident of my daughter and granddaughter]. I was an alcoholic, son of an alcoholic. Well, I would call it a sickness not a disease. It is self inflicted sickness. Well I had a lot of help, friends of mine, I knew I had a problem. I know, now, that it's the last thing you ask an alcoholic to quit. That's scary....Until the doctor told me cause the last binge I done eh he said cause I seen liver damage in your eyes. That's when we started to learn too eh that our people are allergic to booze, the more native you are the more chance you're allergic to the stuff.

A male adult explains his experience of craving for his crutch:

> We come home Saturday night and Sunday morning he [my infant son] was dead. So things just hurdled back. That's when my drinking and drugs turned to ugliness like before that it was kind of partying and fooling around and laughing, having fun. But then it became real pressing, and um, I dealt with the sorrow, through drugs and alcohol.

Another male adult describes his experience with identity crisis and use of the alcohol crutch:

> Had a hard time when I was younger I didn't want to be an Indian. Because of what I seen what an Indian was... just pure alcoholism problems, and problems. I never really looked at alcohol as a disease because it was just a form of life. It was the way life was when I grew up. Everybody that I knew drank. So it was just normal for me to see that. I see it as a very strong disease today. One that is being battled in and the battles are being won.

A female young adult describes the a process she feels is necessary for healing to occur within this First Nation community:

> I think to heal a whole community we all have to start with our own....And then the next step would be within

> your own family because I think once we can work on ourselves then we project that, and you emanate a peacefulness, you emanate that healing....they'll see, oh, it's ok you know it's ok to be me, it's ok to be who I am. It's ok to be proud of what I am....As for doing it for the whole community it's just one step at a time....individuals need to be able to feel that support and feel comfortable enough to ask for that help...healing a whole community, I think, it's gonna take as many generations to heal us as it took to break us down....so you know I'm hoping to raise my children in a way that they won't lack....self confidence in themselves and who they are. Like I told you before when I went to school I was the only native girl in my class, whereas with [my sons and daughter] they can go there feeling proud of who they are and where they come from. So that it doesn't eat away at you [where] you don't feel you know what confidence you have you lose it and hopefully with [my children] it's stays. You don't have the alcohol and drug problems in this family. So hopefully, [with my children]....growing up in that kind of environment you won't see it as a solution to stress, to whatever problems may come up. ....We all have hurts, they could be big they could be small and I think if you carry around those hurts or that pain long enough that's how....you fall into drugs and alcohol....and it may be why...people become addicted because there is something inside then that's broken or hurt and healing is just the word you can use to describe it....and you can't to my way of thinking have a drug or alcohol problem in order to have a strong family. Which is really ironic cause like I said both my parents have a problems with it while I was younger and I guess maybe just growing up in that environment made me realize I don't want this for my own children. Like we never went without anything we were taken care of physically, we had clothes, we had food, we were taken care of emotionally, we knew our parents loved us, so we were really lucky, you know ...The cycle is kind of broken you know....

There exists a different type of unhealthy condition found amongst the adult and young adult sectors that is defined as symptoms of a new disease that is either the cause or is related to mortality. The new disease is stress and depression combined as one disorder. Alcohol and drug abuse is perceived as a symptom of the stress-depression disorder by

the adults and young adults that is related to a sense of powerlessness and hopelessness.

A male adult informant explains:

> Well, I think right now with the young, well even with myself, for instance not working for so long now, and...my wife, being sick for so long. It's, a lot of stress, just builds up, and builds up, and builds up in myself. And, the younger generation is that they can't get a job, you know, and stress builds up there. And I think, that's a big, big, problem with all our people today right here on this reserve. It's stress period. I think, depression, is one of the main reasons why...our younger generation is into drugs and alcohol. And, I, don't know, that might, that might be the reason, they are depressed because of the drugs and alcohol you know.

A second informant reports a variety of health care interventions sought in search of a cure for his crippling body which in his view is caused by stress:

> I went to a naturopath, three of them. Um, the first one, confirmed, what I thought, myself. That I was um stressed out. Cause that's the way I felt inside. I didn't have...the will or determination to do anything inside. Like nothing! It's not that I didn't care, it's just that, I didn't have the strength to, to try and care about anything. I think it was more than that [depression]. It's like, I had a severe drug and alcohol problem, but alot of the symptoms that contributed to my disease of drugs and alcohol, I've eliminated over the years. Not all of them, I've never seen that because I think I'll keep finding them until the day I die.

A third male informant reports his interpretation of the change in this disorder based on his experience:

> I never really looked at alcohol as a disease because it was just a form of life. It was the way life was when I grew up. Everybody I knew drank. So, it was just normal for me to see that. I see it as a very strong disease today. One that is being battled in and the battles are being won....It's a positive...you know, beginning to grow on you. Like I'm hurt because I wasn't able to

> participate in [cultural events] when I was younger, cause I never had the teachers. And now the teachers are starting to come out of the woodwork! The elders are starting to come into play again and I long for that. I long for everything that I missed. And now I feel like a born again Indian. Where it's only just begun. And I can't grasp enough. I'm thirty-five years old and I've only just begun to learn what being an Indian is all about and I love it! And the more I learn the more I can pass on.

The perception of drug and alcohol abuse for the young adult informants changes from a societal norm to a disease that is treatable. Treatment for this disease is currently received outside of this community. People seeking therapeutic intervention attend a Treatment Centre located at a different First Nation. However, success of this type of treatment is dependant upon the incorporation of community and family support and Aboriginal theology. One young adult reports her interpretation of the cause and effects of this unhealthy condition:

> And I could see alcoholism starting um at least two generations ago...both my parents...and my grandfather had a problem with alcohol, my greatgrandparents....if you have a problem with....alcohol or drugs you don't feel good about yourself anyway....the self esteem is just down the tubes you know....I had a problem with drugs and alcohol when I was younger and...came about healing my own self when...a lay person was here...taught me how to play the guitar....and that way I got my spirituality on track. It might not be the Indian spirituality but the way I look at it, I bring my Indianness to this house of worship. And so it's my Indian spirituality....that's when...my life started falling back on track....the support is there all the time you just have to recognize it....it helped I think having your own grandparents. Cause you grow up having a respect for your grandparents....So you kind of get pushed into doing things for the community that you really don't realize you're doing for the community if you know what I mean...I guess that's a way that old people train you, prepare you, you know, they show you

> where the need is and....they kind of subtly suggest that yes you can do it. And it tells you that they have that faith in you to do something. So that support there you know is...a blessing....my grandparents ....they're not going to be there forever....and trying to explain that to my son you know alot of things came to me that I forgot that I had learned about...".

A second female young adult informant provides this interpretation of her experience with alcohol abuse and her preferred method of treatment:

> I'd say alcoholism to me that's a disease. I see it as a disease where someone has to have a drink during the week all the time....I've seen what the Treatment Centre has done for [other band members]....[The teachings that they share with me] like to me it's cleansing...To me it heals the inside, I'd say the physical and the emotional. I think the members would feel alot comfortable if they were held in a home...I think we really do need a support group. I mean [our CHR] has tried to put things together but...I think they just don't want to listen to somebody lecture them....I would do more...visual things....Or maybe do more diagrams or something where they don't just have to sit there and um listen to someone talk....

A male adult, who has experienced treatment for the unhealthy conditions of alcohol and drug abuse explains his interpretation of the change he is witnessing:

> [we're] in the process [to] just getting back to what we were. Like alcohol is not a part of our culture....and...[our culture] is becoming a stronger part of us, like becoming more healthy, you know. Like we've only opened the door to begin the process, there's so much out there to grab hold of. But it's becoming more evident in the native community around us, it's coming back.
>
> But [alcoholism] that is changing today.... Alot of those things were never ever a part of us....
>
> Alcoholism on this Reserve is dying out. That disease, you know I'll be dead and gone before that actually completely phases out but I see the phasing out now it's taking place. And it's important that we get the things in place to keep it going. We need our gathering place

> again. We need to put those tools in place for our young children in the modern world....
>
> It's something that um our elders are now speaking of very strongly. And I try and gather as much information as I can and most of it is coming from elders that go to the Long House....I think we'll win those battles against diseases...our culture will always live and be stronger in years to come.....I think we're going to be a good survivor....cause we'll have [our] type of spirituality tied in with our business developments. It works....you always have the sharing concept in there....we just want to take as much as we need to be able to function normally. To upgrade our standard of living, it's very important to us.

A male adult reported the first step required for healing unhealthy conditions to occur On-Reserve, that is currently in progress:

> Well if, **if** things go right and I hope they do uh [Chief and Council] are working towards um a Cultural centre and I think would really help...right now we got no place to they got no place to go play hockey uh we gotta run around look for a place to play softball, gotta run around look for a place to play soccer. You know whatever sport they're in, we have to go and look for a place to do it. And with our cultural centre I think that would really help out. You know we could, they could take themselves up to the cultural centre and play hockey, play basketball....But I think that would really help. And the Healing circle that [the Chief] had going here right after [name] was killed, I never ever attended but I hear that the people that did come away feeling better.

Definitions of Health, Sickness, Disease and Treatment

The differences in definitions are related primarily to changes in key events as experienced by each generation. For example, the congenital factor is predominant among the adult and young adult sectors and is absent among the Old people. Symptoms of their definitions remain constant. What is not

evident, however are the policies of the Indian Act such as segregation, assimilation and integration nor the actual health care services policies because, as Adams (1973) states, most of these policies were unknown to colonized people.

Health as defined by these people is a state in which sickness or disease may or may not be present. It may or may not include manageable/controllable pain. It is a conscious state of living in that each act is unconsciously performed to maintain health. For example, prayer, proper diet and taking care of others are essential pharmaceuticals to health care prevention and maintenance techniques.

Sickness as defined by these people may include a clinically defined disease such as diabetes or Parkinson's disease. This state of sickness may or may not include pain. The type of pain experienced as defined a sickness is manageable/controllable either by Western or Aboriginal pharmaceuticals.

Disease, as defined by these people is a condition where pain is uncontrollable/unmanageable with either Western or Aboriginal pharmaceuticals.

Treatment

There exists a mixture of Aboriginal and Euro-Canadian approaches for treatment of unhealthy conditions. Selection of a particular treatment approach is dependant upon the

personal experience of the antidote, the evolution of custom, the transition of culture and the adoption of accepted external treatment.

A male old person reports:

> Well, I always feel that like in the earlier years we didn't have doctors so we didn't bother with them anyway. I would say we natives have a problem with our attitudes with these four things [health, sickness, disease and treatment] you know ah the way we used to live and the way living is now. Sometimes we haven't got much faith in the traditional ways and sort of still sort of mixed up. Trying to become a person in the environment we live in and still trying to hang on to our traditions. If I was to go completely back to our ways where would I go to live like that?....But it's um so I would say our attitude is use what we can of our traditions that works, and go by, try and wrestle with the environment we live in.

A male adult informant explains what influences his decision in terms of a particular selection of treatment:

> I, if, I had something that I um the white doctors couldn't cure I'd probably go [to an Indian healer], you know. I should go there first but out of habit we go the white doctor.

A second male adult informant reports his experience with non-Indian pharmaceuticals and what influences his choice in his selection of treatment:

> Mostly just live it [flu] out. I don't like, um, my history with doctors is very minimal, I don't like medication, like, anything. Like, I just like to go through things natural. Cause all the medication does to me, is just, stomach pains, burns and stuff like that. So, I just, whenever I get a prescription I very rarely take it or go get 'em. Cause I have no use for them.

A female young adult explains how she selects treatment:

> if I was in a lot of pain [I would go to the doctor] like usually if I'm sick I usually feel like I don't have alot of energy. Like I've never ever gotten to the point like where I'm in alot of pain. Or for a regular check up I'll

> go see doctor but the only time I've ever seen doctor so much is when I was [pregnant]....it was just from the regular check ups and stuff cause they were so often.

A second female young adult describes the circumstances that influence her decision in seeking western medical therapeutic intervention:

> This last flu was about the strangest I think because um I guess it was a different strain. But it was really, really harder it's not as sick as I've ever been but it lasted a long time with alot of headaches and muscle and I've never had that before. I thought at first it was just from training [for canoe racing], being so out of shape and then [the demands of] training. That my muscles were really sore, my shoulders and then I went to the doctor and he checked me over and he said it was a virus. So I just had to stay off the [training regime for] canoeing. You know go to the old flu stuff, lots of rest....I just drank alot of tea and water and soup that's about it. But it hasn't crossed my mind we're just used to going to the doctor.

In terms of descriptions of states of health among the adult informants, which is absent among the Old people, the younger generation described feelings of being stress free.

One male informant explains:

> [when I feel healthy] you don't feel stressed out. Like me it was not knowing my identity, I was always stressed out. I had anxiety attacks on a regular basis, feeling down all the time, not knowing where to go, caught up in the white world and um being a Native mostly because okay you are an Indian but you never knew how to be an Indian and ah now I'm finding that I can have a foot in both worlds. And be comfortable.

A second male informant provided this definition:

> Well as far as I can tell I'm healthy now.
> Well, now, it feels really good....I can honestly look back over my life...from when I sobered up...it's like my life's been broken down into years of seven...I could only say in hindsight, that, that has happened. The last seven years of my drinking, were the worst...when I quit I emerged myself into seven years of becoming a workaholic. And then...this is my seventh year coming out

> of...illness...while I was going through illness I wasn't saying to myself: Oh well, I have seven years of suffering to look forward to....In a sense, you know reaching another stage in life: of confidence, and everything plus I know how to look after myself. It's given me the tools to do that. So once I got over my back [injury] I said to myself, to the universe, God or whatever...that's it I've endured myself to suffering....if I need the help people are there...to understand....And ah so everyday I just get healthier.

A female young adult respondent provides her definition of health and describes how she helps maintain that state of health, of which diet and prayer is fundamental:

> when I am healthy, it feels good I've got lots of energy like for the past couple of months I've been exercising that's certainly been helping. Fried foods, um I don't eat greasy food anymore I've cut back on the amount of salt that I use, um I don't eat junk food. I used to like my potato chips. I eat alot of rice...fish....seafood....and I pray...when I get worried [I feel depressed]....[when I feel this way] I talk to....my godfather....

Experiences with Western Medicine

Surgery, for the informants who reported such incidents, is a medical milestone that requires time to recollect. Childhood surgery is discussed only after the process of the interview itself initiates respondents recollection of memories. A male old person who reported he had never been unhealthy tells of his experience: "Ah, that is ah a very good question, [have I ever been sick] I was asked by a physician whether I had any records and apparently I have none. So I never was sick".

Later in the interview with him and his wife, he recalls:
Mr: Like you was asking if I ever was sick, I got my tonsils out when I was four years old [at] St. Paul's Hospital.

Mrs: that was his first and only time that he went to the hospital. It's strange eh, he wasn't even born in a hospital. I was.

Mr: ...they had ether, they put a cloth over your face and you breathe it in and you go to sleep....after I went to sleep....I was dreaming that I went to the bottom and I took a dive and I couldn't come I could smell this stuff you know.

Mrs: that's how it was that ether or chloroform maybe.

Mr: and I was trying to come out you know and I was just a little boy. I never did swim but I dreamt that.

Mrs: that's how it worked on you it was terrible. First was chloroform and then come they got the ether after.

Mr: yeah, yeah, they just used the cloth and put it on your nose.

Mrs: it choked you.

This married female old person informant provides another incident:

> And he [my father] died when he was forty-six of spinal meningitis but it was ah neglect of the hospital. He was in there for pneumonia....They put him in a tub to have a bath and they forgot about him...he couldn't get out...So he passed away from spinal meningitis but that was the small pox.

Another male old person reports:

> ...I just had bad tonsils....that's when my dad had to pay thirty five bucks. Ah, anaesthetic, local anaesthetic [with the cloth] mhuh. Oh, then when I was about seventeen I had my appendix taken out...But then after that I didn't bother with the doctor for about twenty years I guess. Never bothered.

His wife recalls: "I had tonsils out after I went back to school. I was thirteen when it happened and my mother kept me out after".

With the old people and adult sectors of the Tsleil-Waututh First Nation evidence of the provision of health care service policies of the Indian Act is present.

A male old person reports:

> yeah, well they were a long time taking me in the hospital. Our medical coverage wasn't very good at the time. My father had a fee for my tonsils to take them out. Cost him about three to four months wages. This was during, just past the Hungry Thirties. I was taken out of school on account of this because my tonsils just festered away into my lungs. They said if you keep him in school he'll get TB....

A female old person reported her experience:

> ...And... then...was the bowel. They were going to take out oh about ten or twelve inches of the bowel. And now I'm on to the BC medical which have specialists and he tested....and finally, he said I think if you eat the right foods you'll be alright. But then I was coming into

the age where the scientists I guess realized I guess if you went off of all these foods because of tiburcucalitis that wasn't very good. So if you took a little bit of the food you're not supposed to eat then it wouldn't bother your tiburcucalitis. So I was fortunate in that era. So I just have to watch what I eat".

A male adult informant reports:

The, only one, I remember getting sick was my brother, he had a touch of polio. My younger brother. And he was in the hospital, I know, for a long time. They wouldn't let us, even, in the room to see him. We had to visit him through the window at...the General hospital. He was in the ground floor window and that was the only place we could talk to him, is through the window.

One day, we were swimming down the beach, just him and I, and he said, ah, he said, [name] I feel sick. I said how sick? He said, ah, I don't know, he said, it just feels funny. So I helped him up to our house and I told my mom. And, then, we had to go all the way to Vancouver to a doctor. Because the Department of Indian Affairs wasn't paying for our doctors that are close by in North Van[couver]. Or anything like that, we had to go up to Vancouver.

During this interview this informant was asked when the policy of Indian Affairs changed, he reported:

Well, my first...experience with that was in 1965 when I needed an operation on my bladder. We used to go to the bottom of Granville Street on the waterfront. The Immigration doctors they were called then eh? And, ah, this one young guy, I went to there, I still remember so clear in my head, when I went down and told him what my problem was. He just sat there like: hmmhump. He gave me some pills and sent me away, eh.

So, it just got worse. So, finally, I went up to um the doctor, we could go see when there was a real...bad problem. We used to go see this doctor, well Dr. [name]. An elderly doctor, really good. So, I went up to see him, over the head of the nurse, that was taking care of the Immigration down below eh...I told him my problem, I told him I was down to the waterfront. And, he asked me, what they did so I told him. And he just blew his stack! He phoned down there and just chewed them right out for that. Why didn't you do this for him, why didn't you do that? And, I went to see him in the afternoon, about two o'clock, by three o'clock I was in the hospital. He said,

I should have been there two weeks ago. In 1965, I think, that's when it started to change for everybody. Same with the dentist it was around that time.

Surgery

A adult male informant recalls his experience with surgery:

Well I had um a kidney stone in 1973. And the pain would come and go come and go. And finally I went to the hospital for a operation and they found out I had two kidney stones. One on each wall of my um kidney. They removed one and said the other one was attached too attached to the wall to get it out without damaging my kidney. Anyway they went through the operation and when I come home I was off work for about four or five months and one day I went to the bathroom and I passed the kidney stone. I mean that's some pain like that. I guess really that's about the only illness I've really has to do with kidney and bladder. Other than that you know it's injuries at work, injuries at home.

A male old person informant reports his experience with surgery:

Yeah. when I was working in the mill I smashed my hand on an automatic lumber cutter two rows that machine is elevated by 500lbs pressure. I hit it right on top of the board. I was working down on the mill in 1985, this happened in 1965 eh, I was working down here in 1985 and I fell down and hurt my hand. Had to go to the compensation board about it. That's the hand you hurt in 1965. Doctor x-rayed it and said there's a broken bone in it. So I went and had it operated on and here there's no bone broken in it. I had to miss a lot of work.

A male adult reports his experience:

A shoulder injury at work in 1988 I was off work for eighteen months. Tore all the ligaments in the rotary cup in my shoulder, my left shoulder, and I was operated on that. Then I got hurt in March operated on in July so I had to wait that long for a bed to become available. And this last Christmas I fell down outside the house here

> and hurt my right shoulder I got to go see the specialist today at 2 o'clock. I don't know what's going to happen.

A female young adult describes her experience with surgery that includes hints of increase in frequency of occurrence of unhealthy conditions a new phenomenon:

> I've had a gallbladder operation last year. That was severe pain you know. Giving birth was alot easier than having those gallbladder problems. But the doctor said it was well attributed most of the problems to being pregnant, two years in a row it out a lot of strain on your body and it I forget how he explained it....And the stones that I had were too small for lazering....and there were too many so they had to remove them and then I had they found I had another problem I can't remember if they said it was in the bowel, there was drainage from somewhere so they had to do a little bit extra and I had to stay in the hospital a few extra days. It was really strange because a cousin, his wife, had the operation, then my mother-in-law had the operation, then my grandma and then me. So it was really strange you know cause all the (snap, snap, snap with her fingers) all within the year....I don't know lately I find diabetes to be really high among native people. My grandmother, my late grandmother, had diabetes, my, her daughter now has diabetes, my Uncle has diabetes, and when they diagnosed that first it was rare for men to have diabetes. My mother-in-law, my brother-in-law, have diabetes so I find that to be kind of strange.

CHAPTER VI

THE OLD PEOPLE'S EXPERIENCE

The Tsleil-Waututh Old people's health care experiences are associated with the life experiences that they have survived. The significant life events of the Depression, World War and Residential Schools particularly as related to diet are all experiences of unhealthy states. The impact of the different health care policies of the Indian Act including both dental and medical service delivery remain in a present state among the Old people. The causes of unhealthy conditions among the Old people are attributed mainly to changes in diet and environment. The exception to this is tuberculosis which was reported as reaching epidemic proportions among Canada's First Nations people collectively.

Residential School

The experience of the Residential school system on the Tsleil-Waututh First Nation's children, now the Old people or grandparents and great-grandparents of the community, included the provision of medical and dental care. Aboriginal children arrived at these institutions because of the different education policies of the Indian Act, one of which was segregation. This experience of segregated education is

remembered in terms of the methods of both medical and dental health care services provided combined with changes in diet. One married Old people couple discuss their experience:

> Mrs: Yeah in the boarding school there would be maybe forty-four boys and forty girls. And each in our own side in the school
>
> Mr: segregation
>
> Mrs: But there was a few there, one of my good friends died. She just got sick and never came back to school and ah I asked around where did [name] go? Some of them would just look at me you know. Then one of the older girls said she died, she had tb. I was so grieved by this. Then I got so skinny, I couldn't eat their food anyway. Then the doctor ordered me out for a year.

A male old person reported the drastic change in environment experienced caused by moving from home and to residential school: "You know, my grandmother's people....I was brought up on love with all of them. Then when I went to school I started getting beat up and pushed around I was wondering what the heck have I left earth or something?"

The type of dental care provided to Indian children at Residential School is an experience that is not easily forgotten, the experience remains in the present moment. A married old person couple recalls:

> Mrs: And then there was our teeth, we'd have these people come into the convent supposed to be dentists....my own experience is that I had a little mark in the middle of my two front teeth. So what did they do? They drilled a hole and filled it with---this is what they said you'll look beautiful after: all silver. No consent from our parents, nothing to kill the pain and they were going to pull it. And we all went in a line, [to what we] used to call the sisters community room [there was] a long table [and] an ordinary chair [for us to sit] when they drilled it they put lead I guess because it stayed shiny for a few days and then it turned black and then it fell out.

> Yeah and then there was a lot of us with gaps in our teeth you know. And we'd have to be very careful not to swallow that filling. Nobody told us that it just came natural if you feel a filling in your mouth just spit it out you know if you bit into an apple.
>
> Mr: they didn't deaden the nerves or anything. Just went right to work.
>
> Mrs: same with the vaccination they just came up there and this was for, small pox, they would scratch, then poured something on there. We've all got the same mark. That's all they did with a needle, scratch and put the medicine on it and that's all! Pulled down your shirt and it got infected and scabby and itchy. Don't touch it and don't scratch it.
>
> Mr: actually our parents should have been notified. Today, it is different.

A third male old person reported his loss caused by attending residential school: "cause we were in boarding school, eh. All of us for years. I never even knew my grandparents growing up. Dentists were there, ordinary chair and doctors we had doctors...".

Diet

The life experiences of the Tsleil-Waututh Old people as related to healthy and unhealthy conditions is intricately woven into diet. Diet, within its cultural context, is of importance because traditionally these people were a hunting and gathering society. This means that food itself would maintain a special place in this society based on acquisition according to seasons, preparation time and preservation. The difference with their experiences in relation to scarcity of

food during the Depression and the war is the external control of food during these life experiences. The maintenance of health in relation to diet then is especially true during times of scarcity. The Tribe's endurance of such circumstances and its effects on the health status of individuals within their society is significant.

One married Old people informants reported:

> Mr: that was quite a life eh from the Depression to the war.
>
> Mrs: it was just a matter of survival that's what we were taught you know as long you're surviving you're fine, you're doing o.k....yeah. And our soup was just potatoes and water. This was during the Depression. That's what we said: we went through a Depression! I don't see how we stayed healthy with the food that we had to eat.
>
> Mr: no butter
>
> Mrs: we went through rationing during the war. But....we were alright during the Depression. Then everybody was rationed. All the [name] were put on rations. I had two kids in 1940. When [my youngest son] went to school he didn't know what a banana was. He had to ask his brother what do you do with this. He says his brother got up and says, peel it. You wouldn't know I said you used to have banana flakes then.

A second old person informant reported his diet during his life experience of the Depression:

> I was in the Hungry 30's. I was about seven years old at the start of the Hungry 30's. And sometimes we'd just have our tea and bannock bread. Sometimes ah our bread was dunked in bacon grease and that was our dinner....And then sometimes we'd just have boiled duck that was all no spuds, no[thing]....Christmas we had fried spuds, fried in bacon grease. And my grandmother gave us kind of like corn beef and we had corn beef hash at New Year. This was my diet.

A third male old person reports his experience during the Depression as related to diet particularly in terms of the lack of services received from the Department of Indian Affairs: "We grew up in the Depression too eh hardly anything to eat. All we ever got from the Department was lard. Rations?"

Causes of Unhealthy Condition

The Tsleil-Waututh Old people possess explanations of a definite cause of their unhealthy conditions. As Old people of this First Nation they have witnessed the changes in their physical environment which have occurred as part of Canada's modern technological advances, such as indoor plumbing. A female old person provided this account:

> So I guess the other ones I had I would say were caused first by chlorination of the water, my kidney I couldn't drink that chlorinated water; then we got running water in the '40's here city water, pipe water--before we used to have water in the creek...or a well. And then the second one the bowel, is the change of food from deermeat, duckmeat, clams, fish we could always manage to get some somewhere. But, all these wildlife what we were living on before then came we had to buy our food from the store. And ah his mother always had chickens....we had the eggs of the chickens to eat....And then we were told that the beaches were polluted ducks were out. You know! It's things like that, that ah, it's hard for them to understand....the food that we have now is different from the food that we were raised on. So that this brings on the kidney trouble: the water, the chlorinated water. And then the different food we have to eat now, I don't know where it comes from. But it's not the same as before. It's made a difference, in alot of people my ages life. So ah, I don't know, you wouldn't call that a disease I don't think. Certain kind of an ailment. And you would say my kidney is ailing me, my bowel is ailing

> me, my head. And then now is, was my lungs: asthma. You might say this is a disease. Cause everybody is getting asthma on account of the pollution. Different things we have to inhale now. Chemical plant up here you know. The oil refinery's across. The trucks passing here...everyday and all day with ah diesel smoke when they come up on the little incline hill they have to change gear I guess and all of the smoke hits here. So we can't have our windows open or doors: hardly anyplace to get any fresh air anymore, anywhere.
>
> The disease is the um tb, and I guess you would call the others ailments. The tb is supposed to be, was, in those, in the early forties was considered disastrous among the Native people. There were two or three sanatoriums around the lower mainland and they were filled. And then um it was like that among the white people too. They, they had a sanatorium at the Vancouver General Hospital. There were few Indians there, there were alot of non Indians there too. It was just something that was you know of that era. And then after that it was nothing.

This couple provided their interpretation of other environmental changes related to technological advances in regards to unhealthy conditions:

> Mr: I noticed one thing...it is very handy this natural gas...what made me think about it is when the old wood stoves what we grew up with about this time of the year or earlier I know all winter we'd have a little pot boiling on the wood stove with [that] bark in there vaporizing.
>
> His wife continues with:
>
> And we had a little oil furnace then plus our wood stove in the old kitchen and that pot sat on the oil stove all day and all night and I kept adding water and changing the [medicine]. And never once you know had a cold or...it wasn't until we got natural [gas]. Well we said we better get...a gas furnace maybe be a day I might be sick he says you won't be able to get the wood or the oil now we're up to the oil then. So I guess I retired in about 1983 that was about the last time I had ...bark simmering on the oil stove.
>
> Mr: there is a difference in the heat. yeah. It's modern but it's not exactly the [best]...another thing it's

> populated real estate is really moved it's circled around here
>
> Mrs: then after he retired he put in a garden grew all our own vegetables here....Fishing that was a meal there. It was healthy then now it's not.

Another male old person provided his interpretation of the cause of one of his unhealthy conditions as related to change in environment and diet. The other unhealthy condition he labelled a disease with no explanation for its cause:

> Well I have a sickness. Not just sick I nearly died....I was sick with colitis. Yeah I got down to 122 lbs. [The doctor] kept me on pills for about two years, three years. Finally I lost too much weight so he put me in the hospital. About in '86. I got operated on two years ago. Yeah, [I have]an exterior bag. Well I'll have it the rest of my life....every time I had a bowel movement I started bleeding. I went to work like that I worked for two weeks. Finally I started getting diarrhoea for every half hour....and at night fifteen times a night I'd get up. At times so bad nothing but blood would come out. Well the doctor gave me some pills they helped me a little bit stopped the bleeding, diarrhoea for a while then it started up again. Finally he put me in the hospital.
>
> Well...I used to eat a lot of roast beef eh red meat...that's what caused it I think. Garbage meals especially when I'm single. Sometimes...I used to go to Vancouver and have two steaks in the same day. I used to cook myself roast beef....It was all that mutton I ate overseas. I was two years in the army. I remember 1953 we had a cherry festival here [now] they're all gone. We have two out back but the crows get 'em before they're ripe. I had a lot of trouble with gout too. Must be a disease I'd say. I'd call it a disease, yeah.

A married old person couple describe their unhealthy conditions and provided their interpretation of its cause:

> Mr: I think your diet was better than mine.
>
> Mrs: Oh yeah, I think because mom worked for white people eh she knew what ingredients to cook up without having so much. We always had a mixture of

something....she went and dig clams herself. My dad went hunting ducks he would deer hunt too he liked to do that.

Mr: well I always thought there was the hazards too like ah when our people hunted deer and moose and sometimes the animals they got were diseased too. There's always a danger of that. And ah I really like to know what I'm eating. Cause we try and stay away from can foods cause we don't know the cannery that's putting them out.

It's best fresh vegetables you know damn well what's in there. I said we have problems enough without looking for sickness. I found out I had high blood pressure....about three years and then it wasn't long after that I found out I had diabetes. Now I'm under the treatment of our doctor, family doctor. And it controls the both pretty well.

Oh like when you get a severe cold or flu I don't go to the doctor. Well [I use] vicks and aspirin [and] I'll be alright. Yes, I would say from where I come from well...they just didn't bother talking about our ways. The only one I learned a little bit from was my mother's father, my grandfather....He's the one that [said] when you have children they have to have the proper diet, and you have to teach them. He says to be respectful, you have to teach them about love, they must have discipline. So we talked about this...had to get all the proper foods, vegetables and fruit. We bought them very little candy, or pop we bought juices....

And I kept remembering...according to the teaching of my grandfather he said your children will grow up strong. If they want to take part in the sports they will be able to. He said otherwise they're weak and they won't have no fight and they'll be listful and no ambition. At least give them a chance to grow up healthy...we tried our best...

I've got to have my bread and my tea...You know like I was taught by my grandfather too like there's nothing greater than sharing your [food]. You sit down and you have a slice of bread together and a cup of tea, that was sort of our tradition...sometimes I'd leave my grandmothers and her sister she'd heat the water up and make the tea and I'd say I already ate auntie and she'd say oh sit down. Bring the tea and a big slice of bannock bread, and we'd sit and talk.

....A disease is sort of different you know it's like I found out that the diabetes is in our family.

But ah I don't know from our environment from the way we grew up it's not an independence we have but somehow up to here we've survived.

And when you get a sickness we believe it's inflicted upon us by our Creator and we just suffer through it until we get better. And some of us believe too, that if he means us to die this time we probably will no matter what the heck we do....Got a lot to do with our attitude towards sickness. I feel sick today and cross my fingers and hope I'm better tomorrow. Cause *when Uncle [name] was talking to me he said our problem is [name] we're eating ourselves to death. With the things we get in the supermarket and with our attitudes* and how do we know that they're as fresh as they say? And there's something to that too, I would say.

CHAPTER VII

THE ADULTS AND YOUNG ADULTS

For the most part the adults and young adults lives have grown accustomed to the change that their parents and grandparents have witnessed. Modern technological changes in the environment have become a part of their natural world. Indoor plumbing, electricity, pollution, restaurants, city transportation, choice of doctors and dentists, hospitals, grocery stores; all the modern day conveniences have evolved as part of their culture.

Residential school has become a memory in the minds of the adults but is an experience that remains with the person the same way that the experience of a root canal or child birth lingers vividly with a human being. These adults are the parents of the young adults and grandparents of the Tsleil-Waututh children. A male adult describes a recent traumatic health care experience that was caused by the health care services received at Residential school:

> like I was a resident of a residential school. The reason why I tested positive....was because I had shots when I was going to the Indian Day school. All of us on this Reserve would probably test positive...but it just relates back to the TB shots from certain [times].... So I went through a pretty crappy life....the catholic schools for trying to change us and that was what I was programmed into, to fit into the white society.

A second male adult reports his health care experiences endured at Residential school: "That part [no freezing] I didn't like about it. It's probably why the people in my generation are scared to go to the dentist because there'd be pulling and extractions without freezing....".

The Adults, those citizens between the ages of thirty to sixty-five, health care experiences deviate from the Old people's experiences. The Residential school experience continues to be present with a change of significant world events. The Depression and the War are now replaced by significant Aboriginal world events.

For example, a male adult informant describes his interpretation of this transition based on his experience:

> In this modern world, like what we're trying to set back up on this Reserve is the old government, the traditional government....Where we bring the heads of families into play and everything that we're doing is brought to them. Chief and Council are only a tool....we're in that process now. If we're ever going to be successful...you have to go back to that old form of government....There's just, too much happening, around, now, today that we just don't have the manpower to be involved in everything around us. Like you're taking over all your own programming: education and health and you need those people to do this. One Chief can't do it, alone; one Chief and three Councillors can't do it all either, it's impossible!
>
> The role of women in today's society is really changing. They're becoming the leaders in many cases....and they're taking over all of the leadership roles because their men are so battered down...shame and guilt, they're having a hard time crawling out of that. It's the women that are being strong and standing up and taking the reins.

A second male adult informant reports his life experience in connection to the Aboriginal movement as related to the cause of his unhealthy condition:

> Yes, my worst, I think...say January 1980 to almost January or late December 1984, I worked for [a Native organization]. And, um, and all the time that I was there, I was o.k. But, I worked long hours for very little money. Sometimes, six days a week and I worked with every component of um socio-economic development. And, my responsibility was personnel and programs....there was a multi use of programs...social housing...social programs...day cares, family services, family in crisis centres, family support homes and...training programs like upgrading, training for child care....I was responsible...for eighty-three staf....I worked very hard at that for four or five years to make sure it worked. But, when I walked out of there um I was totally burnt out.
>
> So it didn't take very long after I left there...about a month later that I was completely crippled with arthritis. They, termed it rheumatoid arthritis....when I say they I mean medical field you know, after quite a few series of examinations by you know the Arthritic Centre in Vancouver; two or three doctors I went to; like three or four doctors I went to see for a second opinion.
>
> But it just kept getting worse and worse. It felt as those somebody had tied wet sinew on my joints and ah it was just drying real slowly...from my toes right up to my jaw. Every bone. Bad! Some days I couldn't stand up....I was bent right over, couldn't hardly walk. That lasted three years...it started to get a little better after three years.
>
> I think...it was an accumulation of too many, too many things. The most I could utter, from within, that was silent itself, was that I don't want anymore, I can't fight, anything, anymore. No more causes, I can't no more, just no more.

A third male adult informant reports his interpretation of the major cause of unhealthy states among his people and the type of community care required for healing to occur:

> You know, especially our people at the Band Office and how there's so much stress up there and um I saw it for so many years and lived it for so many years. That I think they need something like that [Cultural Camp] if they wanna get ahead. You know, like, they have stress day, now, you know. One day a week, they have, stress day off and I think that helps. And, I was just telling my wife, when I was in Council, and maybe, that's, what's the problem because I take holidays from the mill. But, I'd still be doing work at the Band Office, eh. Sometimes the Chief would go away for a conference or something, so, just step into that, into the Chieftaincy and do that. I, never, ever, ever had a holiday when I was Councillor. So, I mean that might have been the problem. About, I think, about two years ago. No longer than two, I can't really remember, now, so many things have happened since then. And that's when I was running like from the hospital, to home, to the Band Office and then to work. I was doing all four things, like, and like, it was just too much. A couple of times I passed out at work and I don't know why. One time my blood pressure went too high, the next time it went too low. So I thought I better get out, you know, I better quit, one of them. So it was Council I let go. As much as I hated to.

Unhealthy conditions, too, have changed among these younger sectors of Tsleil-Waututh. The dichotomy of disease has mushroomed to include the unexplainable congenital factor. A male adult informant describes this peculiar phenomenon:

> [my siblings] all had bowel infections or bowel problems...has a bag one of them....so, it seems, they tell you, you know it runs in the family. But I know on my wife's side there is [diabetes]. But my side it's high blood pressure...well myself...I've had that now for about ten years now. I've been on medication for ten years for that. And, they said, that also, runs in my family. So they said, that, could have, caused my mom's stroke. My aunt died of a stroke I guess...thirty years ago....so it runs on my mom's side of the family.

Childhood disease continues to occupy the same position of the Old People among the adults as it does among the Old people. It is a normal expected occurrence. The experiences of unhealthy conditions are restricted to childhood diseases.

A male adult reported: "I had yellow jaundice when I was about seven or eight years old. And, ah, I can't donate blood because they can't find my records, to find out if it was A or B hepatitis....I had all the other illnesses that the kids get: measles".

Second informant provided his story of unhealthy condition experiences: "Yes, when I was younger I had pneumonia, whooping cough....when I was a kid, maybe when I was three years old or something".

A third male informant reported experiences of childhood diseases and two other unhealthy conditions during an interview. However, it is the process of recollection that is important, in regards to health care practices that medical history intake assessments necessitate. The informant did not acknowledge the two other incidents of unhealthy conditions, which is important for health care practitioners to provide efficient and accurate services in today's society, until he had provided his most recent experiences as an adult. There appears to be a pattern of remembering backwards from present to past:

> ...other than the normal ones you know, mumps, chicken pox, and all those kinds of stuff: measles, colds...It depends, if you're talking about flu then it was just normal with fevers, cough, sore throat? *Oh yeah! [when I was young] I was terribly sick, yeah!* I had rheumatic fever....it must have been around five, six years old cause I didn't get to school the first year, I didn't start school til I was seven. But I [had] terrible like extremely, high, high, fevers. I used to get angry, because um, with rheumatic fever, they said, you know what causes aching bones, is you know, if you get moist feet....you know, so you can't wear runners because you

> get hot and you sweat and then cool off, and then that would cause it. Or I couldn't spend too much time on damp ground and be in the rain too much.
>
> And, I was tested, for number of years for having a heart murmur. But, it, never, ever developed into anything more, either. I was seven when I went to school. Yeah, [doctors diagnosed the murmur] well I did have one because they can hear it. Yeah, I still used to get, periodically, when I would get sick, I used to get tremendously high fevers. Which I think was a carry over from the rheumatic fever. It was always within me to have it. Oddly enough, [my son] gets um, high, high fevers, when he gets sick. Same as I did.

Integrated education in a neighbouring non Indian suburb has replaced the former colonial model of learning for the young adults and their children: the greatgrandchildren of the old people and grandchildren of the adults. The young adults, those citizens younger than thirty but older than twenty-one, possess memories of comfort during childhood experiences of episodes of unhealthy conditions. Diet continues to maintain a position of health care maintenance in preventative form.

A female young adult informant explains:

> We haven't really changed too much. Alot of stews, 'n soups, spaghetti, was always a favourite of ours. We didn't have alot of salads that I can remember but we always had cooked vegetables. So I think it was a pretty healthy diet. Every spring we'd start out with the huckle berries, and then the salmon berries and blackberries and dockle berries. They're real thick skinned type of berry and they grow down near the beach. We used to pick sasspieces um I think they're a salmon berry shoot before they grow into their bushes pick them and eat them. Yeah I guess we did have alot of fish. And there was a point there were we got to have clams....and I guess there were a few times that one of the cousins, relations would go hunting, we would have deer. I remember my grandparents having duck alot. Crabs were another one too that as a young person didn't have alot of but I guess it was just in season we'd get them. But we can't eat anything out of there anymore anyways. It's too polluted. It's too

> expensive to buy, it's like fifteen dollars a pound for crab meat, that's alot of money. But we have sometimes these people come from over on the Island...everybody buys their clams....Some people still go clamming out here on the mud flats but my dad said you shouldn't really eat anything from there.

Childhood diseases such as chicken pox and the measles continue to maintain a position of normalcy, but acquire a modern element of being treatable through preventative therapeutic practices such as immunization received from non-Indian family doctors. Both medical and dental services are utilized by these younger respondents with no reports of fear compared to their parents and grandparents. One informant provided this account: "just the usual things in those days was baby aspirin that we got to take. And I remember I used to love taking them cause of their orange flavour and stuff....I've had eczema as a child. I don't know if you'd call that a disease".

A second informant reports:

> I had the same doctor from when I was a baby until [approximately three years ago when] I started carrying [my baby] then I transferred over here [North Vancouver] cause it was closer. Oh I always went to the dentist for regular checkups....I've been sick lots of times. Well I've had the flu, I've had a really bad cold that lasted for three weeks. I don't do too much to take care of myself when I'm sick. I usually take [over the counter] medication I don't bother going to see a doctor. I've had the measles, that kept me in the house for almost two weeks, kept me out of school. I must have been ten to me it's a sickness [because] that's what it felt like. I know cancer runs in the family [on] my mom's side my uncle died of lung cancer....[Cancer is] the very first disease [I know of].

Integrated education in a neighbouring suburb continues to cause negative life experiences for these younger

respondents in terms of unhealthy conditions. A young adult informant provides her story: "I was in [the hospital] for an eye operation. My left eye used to wander all the time. And the teachers thought I wasn't paying attention...".

A second young adult informant provides this experience:

> I [can only] remember exzema [the doctor] telling me it was contagious and I remember being ashamed about it too and going to public school and being the only girl, native girl in my class like I had my cousin there...we were the only two Indian kids in our class. And it was just very overwhelming and intimidating. It wasn't a lot of fun. And because when you're younger boys don't like girls we couldn't support each other that way. Although the boys seemed to have [it] alot easier you know.

Chapter VIII

THREE CASE HISTORIES: THE PROCESSES OF HEALING

A Tsleil-Waututh's Old person's female experience is provided verbatim to demonstrate to the reader the impact of the sanitorium in relation to tuberculosis. The researcher could not have provided such graphic detail and emotion simply because the Health policy of the Indian Act was not experienced by her. This woman describes the impact of the disease and the moment when she discovers her personal power and alludes to changes in the health policy of the Indian Act. This story substantiates the researcher's recommendation for an investigation of the Health Orders in Council and its influence towards health care practices of Indian people. In addition, this information is provided because of the researcher's experience with tuberculosis. The researcher was not infected with the disease but did receive preventative measures from European practitioners that was part of the health care policy during the tuberculosis epidemic among First Nations people. These preventative measures, specifically the innoculation of BCG, are presently being reviewed by European health care practitioners within the province of Ontario and preliminary reports suggest that the BCG innoculation may place Aboriginal people at greater risk for tuberculosis.

Case 1: Tuberculosis: a mother's experience

Tuberculosis is a disease that has been reported as reaching epidemic proportions among Aboriginal people in Canada. Since it is an infectious disease, the Indian Agent possessed the power to quarantine people which included sending people to sanatoriums. However, as Manuel (1975) has documented during the time this Tsleil-Waututh woman would have experienced her episode of tuberculosis: "There was an excellent sanatorium in British Columbia, but in those years it did not accept Indian patients; provincial policy at that time was to ignore the existence of Indians in providing public services. Federal policy was not likely to cover the costs of such an institution (p. 100).

This Tsleil-Waututh grandmother describes her experience:

> Yes, quite early I was ah quite ill....they called it tuberculosis. So I was in the sanatorium from 1938, the end of 1938 to the beginning to 1939. And then home. And then in 1942, April, September 1942 I went to the Coqualeetza Sand. Started treatment on me. That was the end of the tuberculosis. They started humorthorax on me.
>
> But I guess I was one of the fortunate ones that, they, previous to that, they were putting all the names of the Native people in a hat and there were doctors who came from Europe, the war. After the war was over in Europe who were great physicians. So then they um put all the Native peoples names in a hat and drew out who would have an operation to remove the lung. So ah, when I went in we didn't know any of this, we found out after, that they were experimenting.
>
> So when I went...in to Coqualeetza they said that they were only going to put air into my sack that covers your lung. The humorthorax and then they'd put a needle in and then that way the air would go in and they could measure it by 500 cc's of air and it started the treatment and

then I came home....for eighteen months I had to go to Vancouver General Hospital for the humorthorax. And after that it, they tried to send me back up there. But my own physician, he was looking after all the Native people in the lower mainland, and he said that, no more Coqualeetza. He says, she's going to die of something other than that lung because that lung should be there. It was never in my you know how the tests they take? But it showed something in the x-ray....No matter what this nurse says....And I wasn't sick after that.

You could always tell a person when they had the lung removed because they walked....(motions bent over and caved in) it was nothing there eh so they was slumped over on one side which ever lung was removed. When they remove a lung they take out your rib to collapse the lung. And so then we, you may have three or four ribs removed and then the lung collapses. And that way there's a void there. There's no ribs there to hold you, you know. So they walked like that. Slouched. You could always tell. But we never knew that they were experimenting.

Only until after when my doctor says you're not going back there anymore. And he told that nurse that. And he was one that came from the Second World War. He was one of the best physicians. And he was looking after the Native people. He performed some operations that were really, you know, great. So, I never went back. They told me you know, when you leave here, first they said we'll pump your stomach. And ah, and whatever comes out of the pump we'll put it under ultraviolet ray lamp for six weeks. And after six weeks it will show if there is active TB germ in it. So well, I went along with that because I wanted to get home. I said ok. And they brought me and stuck this rubber tube in my throat...pushed it down and it got stuck here (motions where) eh where the smallest part is. And all of a sudden it went (motions through) it made a noise and then they pumped it out and I was watching what was going into the basin. So then they um, they put it under the ultraviolet ray lamp in their lab.

And I told them I'm telling you right now I said if there is no TB germ in that after six weeks I'm going home the day you give me the results. Just bring my clothes and I'm on my way home. So six weeks after that and all this time I was praying you know. Cause I didn't feel sick. You know I was healthy looking.

And then one day he came in, that afternoon, after six weeks he said, well your test was negative, there's no TB

> germ. And then I told the nurse go and get my clothes. And I was out of there within an hour. I just walked out!....And I told them when I left there, I'm never, oh you'll be back in six months he says, I'll never come back here. But I, I did you know I prayed and prayed because I had two little boys at home. And mother-in-law was looking after them. I just ached for them everyday *but why I'm there is because you know I don't want to, I think I have this disease, and I don't want to give it to them. That's why I went*. That's was just an awful six months away from them".

Case Two: Holistic care

A male adult provided his experience in seeking treatment for the stress-depression unhealthy condition and what influenced his decision to select a combination of treatments. This case example is provided to illustrate the phenonmenon of holistic healing methods and assists the researcher in explaining the concept of holistic care from an Aboriginal perspective. The reader is reminded that within the Medicine Wheel of Aboriginal people the societies of Asian (yellow), Afro-Americans (Black) and non Indians (Caucausins) are included within its parameters. This assists in explaining utilization of their treatment practices.

> Um, there wasn't anything, there wasn't anything, medically; holistically; that I didn't do. I tried everything. I did everything that I possibly could. I started off in the medical profession, first. And, um, I tried every anti inflammatory pill that they'd recommend. Absolutely, none of them helped. So, I asked the doctors, what are my expectations in taking these? What can I expect? And, he said, for the pain to stop, to go away. And, none of them, ever did that. All's it did was raise havoc on my kidneys and liver and contributed to making me sleepy.

Um, but I honestly think that antibiotics and that kind of stuff, that, they make things worse. Well, for me. [for example] like I was having a bad cough and it was surface. And, I took antibiotics and then it seemed to go deeper down into my chest. Before that, it [congestion and phlegm] was all coming out, like, you know. Same with cough remedies, I don't know if it's psychological or not, but, I, um, seems like they make me cough harder. So I don't take anything. They always say it's a natural process like you feel better you go through it.
Um, the first naturopath that I went to, he um, he did blood tests on me. And, um, he said that stress, stress falls into your blood cells, run in a variety of different patterns....like they create a "U" or an "S" or squiggly line but they're a series of lines, holes in the blood cells. And he said that generally they're pinholes. He said [mine were] silver dollar holes....massive! He said [he'd] never in his life seen anything like it. Plus ....he identified that I was allergic to certain things. Like I was allergic to tobacco, and to weeds and to nicotine.

And um, it immediately made sense cause my diet during those four years at the [Native organization] consisted of mainly bread and coffee and smoking. And I was a funny kind of smoker I didn't smoke during the day, but after suppertime....I'd light up my first cigarette but I wouldn't stop until I was [almost asleep]. And, um, most of the time I didn't have time to go for lunch. The ladies always made bannock at the [native organization] so I just walked downstairs and I bought whatever I had time for. Like even one or two pieces of bannock. And I'd have that for lunch. That was daily and I just drank coffee all day. Mainly because it was there and available and it was too difficult, in my mind, to go and get juice or tea or water or anything else. Ah, so all of that made sense so I had to eliminate that from my, from my diet. I went to re-birthing, a holistic healer [who] sits and works with you....they work you back through your life, to try and bring you back to as far back as you can remember. To dig out any kind of um hurt or pain or unfortunate feelings or thinking things that you might have hidden along the way. And, you do this breathing, ah you breathe in and out at different paces, sometimes very rapidly, sometimes very long and deep. And you immediately breakdown, like what we have in the sweat lodge. Um, cause after awhile the breathing quite often becomes um sort of like chanting or crying or whatever, you know. Cause after a while you know you start to feel like hollering you know. It's like, I guess, the silent scream that you carry around the whole time inside. Like

it's finally starting to come out. Ah, so, I did that about three times.

I took a number of massage therapies. But I had ah three different therapists work on me. But three of them were consistent, not one of them would touch my back because they said....muscles, and the tendons and the stress and everything was just so ah tight in my back that it ah they couldn't they didn't know where to start, so they didn't lay their hands on it at all.
Ah, yes. I went to a few more naturopaths from there. It was hard putting thoughts and thinking together, too. Um cause at the time, even though, I was, trying desperately to help myself, it was hard, to think, of myself. Cause it was hard to put all this stuff together so I just, I just kept trying to help myself, which, was ah local right?

Ah, I did that [rebirthing] about three or four sessions. [I] was also working with Indian people from [up north] in that point in time. And then we had this big spiritual gathering....and ah, they all seemed to sense that I was that I was sickly. They um all helped me out alot. So when I got up to that Gathering ah I was fortunate that there was alot of [Indian] healers there. See, they worked on me in the sweatlodge....you know, apply pressure to where the pain is and just ah make moves. Like, its, [was] described like everything was stuck up there....it hurts to move because it needs to go beyond that. It's like when something is rusted, you know. You know, the first movement it squeaks, it grinds, but if you oil it and move it around, after awhile it gets pliable again, after awhile, right?....it was just painful. It's like um I screamed at the top of my lungs like, ah, in pain. I didn't even care like the sweatlodge was big but it was just packed. They were always constantly praying for me the whole time. Praying on me while [the healer] was doing the work. And um, once the pain went beyond, um, where, it didn't matter anymore, you know, kind of, where you reach a certain point and then everything shuts down like it doesn't matter like, then I started to cry, in honour. Um, once I started to cry, I couldn't stop. I cried continually for four hours. The comparison to, what I felt like when I walked out of there, is like, they drove me down there because I was never capable of walking very far or fast....the other thing I couldn't do, it was even hard for me to walk on the rug with bare feet because my feet hurt, my ankles hurt so bad. Yeah, like I never got twisted or anything but it's just that everything ached so bad that I couldn't move. Like my hands were so weak I couldn't even take any kind of cover off of anything. I couldn't even

lift my hand up to open up a cupboard. Couldn't tie my shoes; couldn't even pull my boots off; couldn't do anything! If I got down into a bath I couldn't get back up.... cause the most I could do was walk with a shuffle. It'd take me a full hour and a half get into Vancouver. In a bus, I didn't have a car at the time. But I mean I'd have to sit and rest at places before I could get up and get onto another bus sometimes. But when I got on to a bus....well, I had to get in and pay and grab on to something. Hold on. Get a good grip on it because when the bus would take off eh that movement would make me fall over. So I could never walk on a bus when the bus was moving because I would fall. The most I could walk was with a shuffle. It was very small steps. To get up out of the chair it would take me forever....

When I was finished the Sweat, I walked over on the rocks and gravel, to the creek, knelt down and bathed myself in the creek, then got back up. Then when I was finished I walked back up to the camp. Which would have been the longest piece that I ever walked for a long time. And, ah, from there on in I started to get better. I never got better immediately, you know, it's like you're gonna make it out of this. And up until that point, I never exactly, had that thought, in itself. And, ah, up until that point, until I got worked on in the sweatlodge I had always held on, in my mind that I was going to get better: someday. I'm gonna get better and this is going to go away. This is going to go away. Sometimes I'd say that and, um, I guess, you could, almost, call it prayer, but I'd just say that over and over. But, this one morning when I woke up....and, I was laying there looking out the window and I thought to myself, I am better. That's right, I'm not going to get better, cause, it's like waiting for it to happen, I am better. I'm better today. And, so from, that's what I locked into, and believed in, from there on in. So, when anybody asked me how I'm doing? I said I'm alot better. You know it won't be long and I'll be totally better. I [have] a little residual here [in my right arm], it's locked in here. And its hard to explain because it seems that its locked which is weird because there's no joint there. You know, having traditional knowledge I could have went [to the ceremony], at that point, in the Long house. And I would have been getting rid of everything that was wrong with me. But, um, I don't like doing anything where I'm not going to follow through [and the ceremony requires at least a four months commitment]. But I've been told by elders and what my gifts are [and] I have a role and a responsibility [as a leader] and um, so I didn't go into the Long House.

Yes, I used alot [of Indian medicine] myself....I made [herb] tea which is a cleanser; some [tree] bark which is like the essence of um [herb], well it's a blood purifier; it's used mainly as a laxative: but if you only take small amounts of it daily it's really good for the blood. And then I used alot of [plant]. I used to eat it as well as apply it directly. Cause they said you know if you put [plant] on to the areas that aching like then you can shoot out the poison.
And then I took to all kinds of herbal vitamins you know, for different things that I was lacking. So I was constantly doing things, I was constantly doing things holistically to um, make myself better.

I even went on a diet for about six months where....it was positive and negative diet. Because according to that naturopath anyways, he said that our systems are only, we're only designed to digest certain things at a time, not a smorgasbord. You know I never gained an ounce for that whole year. I could eat whatever I want, as much as I want, and um, my weight never changed. My metabolism was so well adjusted from being on a diet. I mean everything in my system got working so well ....you know my metabolism was so well balanced from the diet that I was on I'd never been so clear in all my life as when I did that. My eyes, and my ah sinus, my ah, complexion, everything was like just um like sparkle really. I went down to 155 pounds but I didn't feel unhealthy. I looked unhealthy because I was um you know all crippled up, eh? It's odd that I felt good at that point but physically I looked lousy!

Yes, um, I'd like to write a book on it sometime but ah on the whole experience. Because, now, I see other diseases um other illnesses um I'm almost 100% convinced, that alot of the stuff, that we go through, doesn't matter what kind of illness, can be stress related. With me now it's like a barometer it's um it's a safeguard for my health. Because the moment, that something starts to stress me out, the moment that I'm starting to get too tired, I begin to ache, and it starts in my ankle. My um left ankle and will go to my right, if I don't take care of it, or it will ache in both places and if I still don't take care of it, it will go up to my knees or get into my wrists.

Like right now I'm just a little bit tired from ah from everything that I've been doing so this wrist is aching. Ah, to me, like, from my experience, what I've gone through, it was the spirit that was low. My body that was low. I was more sick than a disease....I call it arthritis because that's what the doctors called it. Even

when they called me, I didn't believe it. Because, they did all kinds of blood tests on me, they couldn't find nothing in my blood. That said yes this is [rheumatoid arthritis]. So when they ran out of words, well, they just said, well, you have rheumatoid arthritis.
I said what the hell! We can't really find anything to confirm that. They just said rheumatoid arthritis because rheumatoid arthritis mainly ah is affected mainly around your back, and spinal area, and spreads out from there. And ah, my back was the most inflamed. And, the story of that um it was only just the nucleus, my whole body was. So, no, I didn't honestly, to this day I don't really accept the term rheumatoid arthritis or rheumatism, because um they're just words. The medical profession doesn't even know where it comes from, they don't know what it means, you know, they don't have any cure for it. Stress best describes in English terminology the accumulation of emotional um releases that I never let go of.

You know, I stopped work for maybe a week when my father died. I was so busy co-ordinating and taking care of everything that I didn't even have the chance to cry. And, then, even when it came time to cry I couldn't cry because I was concerned with everybody else. But the um the boy needed to grieve for his father. So there's all kinds of stuff like that I held on to. See those kinds of things, I know, now, what bothers me. Like I can deal with it. Like I talk to [colleagues] about how I felt and ah talk to [my wife] about how I was feeling and why I was doing the things and see everybody, is understanding and able to give me feedback about it.
That makes me feel alright [when] I talk to people about it. And, um, cause we, generally, always tend to be alot harder on ourselves, in understanding and accepting. But at least now I'm not holding on to it. Um, I unload it as quick as I recognize that it is there. And that helps alot.

So, I think, it is, my um, that's my major area as far as um illnesses go. Even, if, I do get the flu, now, I know, I know damn well that comes from being stressed out. I don't even pretend to say, oh yes, well maybe it's [a virus]. During Christmas time I got the flu and I had to stay home a couple of days. I should have stayed home all week really. But I didn't. But at least I knew enough that I needed to lay down for a couple of days. But you could have seen that it was going to happen because I, you know, [with my two sons leaving home] I had this major letting go to do. And ah, by the time it was all over, it was just [sickness]. I probably did pick up a virus but at that point physically, mentally,

emotionally, everything was so low that I couldn't combat it if I wanted to. So I got sick.
I just took it easy. Try and eat really good and um drink alot of water and ah rest. I think I took a drink of [Indian medicine]....that is used up the coast very, very potent cod liver oil kind of. The elders always said that it's good for colds. So I took a teaspoonful of it and well it cleans you, it cleans everything out for one thing.

It took about another two years after, like, up to 86/87, [in 19] 88 I was um almost back to normal. Um, well I was just starting to get better from all of that and then I fell off my porch then I went back to medicines again. But that time round I um got hold of um medicine lady up north, she gave me a whole bunch of medicines, stuff to apply on the outside. Both [plaster and a rub]....She gave me a big sample of [medicine] and ah she said that [medicine] hold[s] the heat very, very, well, for a long time. Plus then she gave me um, something um six quarts of something to drink. It was a little bit [bitter] but for herb tea bark kind of stuff it was kind of like, it was kind of sweet....not sweet like I would imagine sugar but compared to our bark which is generally bitter.

My back's 100%, like you know I don't have any as a matter of fact it's better than before. Cause I had one of those kind of backs where you could just could bend down and pick up a penny and ah it would lock in you know and I would be stuck like that for three or four days, you know, really hurt. Never happens anymore.
Not that I know of [I don't have a disease of addictions]....I guess they [doctors] term it as a disease, don't they? I accept that I can't do that. It's like, I know if you had arrived at having cancer you know you smoke all the time, they say well you can't smoke eh? Well you know, it's not going to help. Cause every stage of life seems to uncover a new, you know, a new, something else is wrong with me. But um, alot of the stuff that I ran away from I guess that I wanted to, that I wanted to obliviate, when I was younger.

And I won't. I won't accept illness. And if I do then I know what causes it, like I did at Christmas time, it's like I wasn't thinking that way anymore, thinking positive, I was very down and torn and broken up about the boys going away and so I just got vulnerable....right now I'm on a diet and I feel good about it. You know it's just weight watchers. But ah I did weight watchers before the whole time that I was doing it, it was like: Oh, God this is a suffering, right? This experience is different because um I'm honestly tasting the food: it's not bad.

> You know it's good to eat ah, I'm actually coming to like the ah, vegetables and the cravings for that being more, more than hamburger and a side of fries. Because now I'm at a stage where I don't like how I feel after I eat a hamburger and a side of fries. But gimme a huge plate of um of salad and I like how I feel.....my energy level has changed. It's different. And I'm enjoying it. I like it. I've been going for walks, an hour, three hours a week and I'm enjoying that. But it doesn't seem very long and I'll be able to run again [because I am a runner by nature]. But I got that sensibly too [because of my unhealthy experiences], like I'm not going to try and get it up to a point where I'm running six miles a day, again. I'd just be content like if I can do six miles in one week you know. Just go out for one run".

Case 3: The Healing Circle

The researcher provides her observation and participation within the Healing Circle to explain how European interventions may be inappropriate. The context of the voice of the people are provided to assist practitioners and social workers to listen to what is being said and how it is being communicated.

> The death of the young man was caused by a hit and run accident. The young man was an active member in the community, well-liked by young and old. A canoe racer, charmer, the kind of fellow you meet and instantly like. A positive role model for children. And in an instant he was gone. He could not be mourned, the people could not grieve. Anger confused the people: his mother, brothers, sisters, aunts, uncles, cousins, friends, Chief and Council.
>
> The accident was not simply a mishap that people learn to live with. This accident exploded within the heart of this community: a second time round. Alcohol was involved. But more lethal than alcohol was the narcotic of racism: a loaded word, ugly and uncomfortable. Undeniably a reality for Indian people.

I arrived in the community as a student well after the burial although the Chief and I had made my placement arrangements within all this turmoil. There was something in the air, a change in feeling or atmosphere compared to when I had first visited this place two months before. The people continued to be cordial but the smiling was gone. The pride in themselves that was previously displayed in the way they held their heads high with their laughter was absent. It was eerie: you could feel the death, touch their sadness.

I had been in the community for two weeks and was beginning to become relaxed and acquainted with the Band staff. One of the employees, one of my significant informants, much to my astonishment, was the sister of the deceased, I could feel her loss in her breathing, slow, heavy and intentional. The Chief, the backbone of my research, my soon to be mentor also breathed the same way. It felt as though if they did not consciously remember to breathe, life for them would stop, that quick, that easy.
There was nothing I could do as a social worker or as an Indian. The door had not been open for me to enter their sorrow. One day, in all his nervousness the Chief requested that I attend a healing circle for the victims of the accident. Something had to be done for the people before it all got out of hand. I knew what he meant, he did not need to explain any further. This was the year of Oka, the army, the year that every Canadian witnessed racism and Indian people on the Journal.

The night it seemed was darker and colder than usual. The Chief had not told me what my role was. Did I have any authority in this group? Was I to be a silent observer? What did I get myself into? How could I help? As a social worker this was one of my most powerless moments. As an Indian I was not sure what to expect. I questioned why non Indian experts were being brought in. Perhaps, it was because I truly believe, as both a social worker and an Indian, in people's right to self determination that I never verbalized my questions. I chose to observe, to listen, to learn.

There were two non Indian experts: one police woman and the other a 'Grief' specialist. They looked safe enough like someone I could trust with my children---maybe? The police woman was close to middle age with a robust laugh someone I thought would make a nice aunt. The 'grief' specialist was older---almost an elder, definitely an old person: wise and comforting. For their people I believe this is who they are: good human beings. What they offered though was culturally inappropriate.

The community people who attended were an elder, the Chief, four women ranging in age from teens to early thirties; and, another man. I knew the elder, the Chief and one woman. The remainder were strangers to me, people I had seen but had not yet spoken to. We all sat surrounding a long, rectangle table with a British Columbia Indian symbol of some sort. It was a hand painted symbol of the sun perhaps with points representing the four directions. A good place to start said the Indian in me.

The session opened with introductions of names. The Chief introduced the experts. The police woman began by describing the process of investigation into the accident, the restrictions that caused delay in answers for the community. Silence. No movement. No response. The 'grief' specialist confiscated the silence. She began by stating that death is something everyone experiences. True enough. Then she did something out of the ordinary to me, she picked up her candle and inserted it into it's holder and lit it. Then she exhibited a picture of the deceased and requested everyone to tell a story of him.

As an Indian I was shocked, stunned, I literally bit the proverbial tongue. People's heads were down, I could hear the women's sobs, see them wipe their tears before they managed to fall and there was that intentional breathing for life. I struggled to maintain their right to self determination. Besides what did I know? I was simply a visitor in their community, they were doing me a favour by allowing me to conduct research on their Reserve. Things would be done according to their custom, it was not expected for me to interfere, and the Catholic church is part of their custom. Regardless of how the Indian felt I knew the social worker in me would take precedence tonight.

The 'grief' specialist continued in her request to have all participants tell their story about the deceased. He was described as a leader, a team player, a shoulder to cry on, the kind of guy who would give you the shirt off his back. All true. So I thought okay this is working for them. Everything's alright. No need to panic. The time arrived for the young man to speak. He told a story of their adventure during a canoe race. One of their competitors were trying to cheat to win by hitting at their canoe and grabbing at them with their paddle. Then it came that, subtle, non insulting, message in the form of profanity but part of the story. The gist of his story was his pride in the deceased in telling the canoe race competitors to F---. The moral of his story was that what was happening was not right. I knew it. I heard his

message loud and clear. My question was: did these women? Perhaps they did because they never did return to the group although they had agreed. There was never any termination on their part and I wondered why?

At the conclusion of this session the Chief and I walked to his home to wait for my husband to pick me up. I had to know if he heard what I heard, if he felt what I felt, if he was going to change things with this group. His response was yes on all accounts but that it was more important to offer something to the community now before something happened. We talked about him, how he was dealing with all of this responsibility, with the grief. We talked about what I saw in him, happening to him as both a social worker and an Indian. He was okay, he just needed someone to talk to, someone who knew of the politics involved in the accident, the racism, the anxiety, the anger that was intensified by Oka.

The group reconvened the following week without the two non Indian women. The Chief was out of the community. The elder took control, everyone needed him to. He brought me into control, into the leadership role: as an Indian. He asked one question:"what do your people do when there is a death"?

I described the different kinds of deaths: natural, disease and yes, accidents. I explained how in my home we have the Trans-Canada highway 17 running straight through the middle of my Reserve. How as I child I witnessed accidents, my form of entertainment, especially on weekends when we knew drunks: both Indian and white would be driving. Sometimes cars rolled, sometimes they crashed. Sometimes people were just injured other times they were killed. Some Indian people, sometimes relatives and some strangers: white people. But I couldn't recall an accident that involved so much racism so clearly.

I brought the situation back to them but I knew it was important to them that I know exactly how they felt. How this accident was more than a death. That the judicial system was something that caused them concern. Legal justice was the way to help put him to rest. But would justice happen for him? I used their symbol of the sun that was painted on the table: a different form of the medicine wheel. We talked about the meaning of the symbol, we share stories about who we are as Nations, we laughed. We did not talk about the death or the accident. We agreed to meet again the following week.

I met with the Chief to up-date him on the previous week's meeting since he could not be there due to his

responsibilities as the Chief of this community. Those responsibilities take him away from the community quite often, a part of his job he is not too crazy about. But he continues to travel, for the people. He is a natural leader, a good human being. I discuss my plan with him for next week since he cannot be there again. I show him how I have used the Circle to explain the feelings that come with death, and yes, I have even managed to include racism in there. I get his approval.
When the group meets the next week there is myself, a young man and four women. I am shocked to learn the relationship of these people: the young man is accompanied by his wife and three sisters, siblings of the deceased. There is silence. I need the moment to think this all through.

I apologize for not knowing, for sitting so silent last week. I explain had I known I would have conducted myself differently. I explain that I am not a grief expert, I am simply an Indian who is a social worker. Which means I can take things like a death and help explain feelings that most people feel but I can explain them how we feel. I can talk about spirits, anger, love, sadness, dreams and fears the way Indians feel them and know it to be true. I can accept things at face value because I come from the same culture but I can also help explain how these things are not accepted by non Indian people or explained by them in some other way.

I show them the circle with all the feelings I have heard them and other people in the community talk about and that I have seen people feel. Anger, confusion, denial, shock, blame, victimization, powerlessness and the dream to have a little Oka, all in the name of justice. I talk about our values of respect, the belief of what white people call reciprocity and our love of life. The tension builds as we discuss the racism, it is like trying to describe a scab, a sore that is infected and oozy. No matter what word you chose it just simply does not describe it exactly, precisely. And that is the metaphor I use: a scab. Everytime we get angry and want to lash out to hurt someone it is like picking a piece of that scab, it never has the opportunity to heal. Our anger is like an infection, untreated it could travel through our bodies and cause us to get sick.

I can see the young man is buying my stuff but somehow I am just not reaching him where it all makes sense. So I am brave and ask: "All of this anger, this hostile action you want, is this the way your brother would have done things". At that point I wished for a punching bag that boxer's use, so that I could offer it to him. I was not

afraid for my personal safety or the other participants of the group, I was afraid for this young man's safety. If he had reached the point of his anger where he could not repress or control himself, would we, the other members of the group be able to keep him safe?

My question it seemed was the right question because he answered no and began to cry. They all cried. I just sat there and said it okay to cry. The crying was not angry or hostile it was sorrowful weeping. They all sat there for sometime with their heads bowed weeping. For whatever reason I knew just to sit there and for whatever reason I knew to offer kleenex when they began to wipe their tears with their hands. And then asked if they felt better.

They laughed, wiped their tears and answered yes. He asked:"how come you're not crying"? I answered if I had started to cry they would have had to counsel me. Help me explain to myself why I came all this way to go to school and all that kind of stuff which really is the Chief's job. We laughed. We joked. We talked some more about the circle and then we talked about the first meeting. They talked about their discomfort and how it only made them more angry. They said that woman had no right to show his picture because she did not even know him. I agreed but also explained that I was told that for white people that works. Those women were not wrong, just different and sometimes different does not work for us. Sometimes for people who are hurting it is better to offer something similar or at least familiar.

The group continued to meet until the week before Christmas break sometimes they all came, sometimes there was just the two of us. As a social worker I felt that as long as I could somehow help one person in that family to recover from the death, in the end I would be helping the whole family because they would now have that one family member who had recovered, who was strong, who had accepted the death. As a social worker I never knew if what I had done had helped or hurted, until I was formally conducting interviews and was told the healing circle had helped. There was no need for formal termination on their part or on mine as a social worker because I knew as far as the death was concerned people were starting to heal their spirit.
During my time in the community the legal issue had not been resolved nor had the political one been settled. It was simply a wait and see situation. The pain was still there and so was the anger but not to the extent where people were talking about a little Oka. Their anger was being replaced by disgust and disgust was an emotion they could deal with. As an Indian I was relieved even though

I felt their frustration. I shared in their pride when I participated in their fund raising activities for the Memorial Canoe Race dedicated to the deceased young man. I witnessed their sense of nationhood when the donations arrived at the Band Office for the memorial canoe race from non Indian and Indian people alike. Due to my personal time restraints I was unable to witness the race I had left the community in June.

In hindsight, as a social worker, had I known the relationships of the community members to the deceased young man on the first night of our meeting I would have done things differently. I would have seized the opportunity and helped those women learn about cultural differences because I believe they will again be in contact with First Nations people. I would have helped them see how their helpfulness was culturally inappropriate and why. I would have talked about the picture, that repulsive newspaper clipping, and explained how offensive it was. How painful it was. I would have asked for a planning session between experts. I would have removed the Chief from his leadership role to allow him the freedom to grieve with his people instead of having to hold on to his grief. Hindsight, they say is 20/20 but in this case I hope people who read it will realize to use the resources of the Indian community; evaluate the political aspect as well as the cultural aspect of the situation at hand. And at every point of investigation to remember to utilize the human feature of the situation.

Chapter IX

DISCUSSION OF RESULTS

Prior to the arrival of European people among the Tsleil-Waututh, according to their oral chronology, unhealthy conditions were limited to curable maladies. Curative treatments were prescribed from their natural health care system of practitioners (medicine people), utilizing their original pharmaceuticals (herbs, roots, teas, salves) and health care institutions (Long House ceremonies, sweatbathes, cold water cleansing). The lifestyles of the hunting and gathering semi-nomadic Tsleil-Waututh society possessed health promotion and preventative measures. The daily activities of food gathering and preparation, canoeing, long distance running, cold water baths, Sweatlodge and Long House ceremonies all contributed to health care maintenance. Epidemic mortality was not related to the unhealthy conditions present among the Tsleil-Waututh prior to contact with European people.

The Tsleil-Waututh attribute their experiences with the infection of the Black Plague and Smallpox diseases to contact with the Europeans. These foreign diseases have created the dichotomy of disease among the Tsleil-Waututh, that is the phenomenon of an Indian and a white man's disease. The phenomenon of an Indian and a white man's disease is

influenced by the mortality rate that the disease has caused. The occurrence of epidemic incidences that results in death is significant. An influencing factor of this phenomenon is the inability of the Aboriginal health care system to treat the diseases combined with the knowledge that infection was purposely transmitted to the Aboriginal community by infested European mercantile such as the Hudson's Bay Blanket. All of the Tsleil-Waututh respondents recognize Black Plague and Smallpox as a disease.

With the arrival of the Missionaries among the Tsleil-Waututh, their natural health care processes were interrupted causing the Aboriginal theological health care component to be replaced by Catholicism. The Aboriginal theological health care component contained ceremony, ritual, tabu and individual power that centralized the prescription of pharmaceutical use within the Aboriginal spiritual realm of ultimately restoring harmony with the individual and her/his universe. For the Tsleil-Waututh, as previously cited, the decision of the grandmother to relinquish her power to practice the health care system of her people continues to be respected by her community's descendants. The interruption of the health care system also involved a change in the methods used within the Aboriginal theological component that dismembered the Aboriginal pharmaceuticals and institutions from the natural position of medical care within their health care system. The processes of ceremony, ritual and tabu that

were intrinsic to Aboriginal theological healing were succeeded by Catholic ceremony, rituals and tabu.

The natural foods of the Tsleil-Waututh in their uncontaminated state were also considered to be fundamental to preserving states of health. Diet is perceived as contributing to both health care maintenance and prevention of health care problems. Deviation in diet is considered to create health care problems but can also assist in the maintenance of health care. For example, salmon and berries, once the root of their diet, has evolved to be unsuitable for consumption within their natural territory. The contamination of these foods can be largely attributed to the evolution of technological society in Canada, specifically the effects of pollution of the Tsleil-Waututh land and the Burrard Inlet that limits or eliminates the customary hunting and gathering activities of this First Nation. As a result, the people experience difficulty in accessing these foods for consumption at a rate consistent with a hunting and gathering society. The lack of access to these foods is due to growth outside of their territory and due to high cost of such luxury foods at the grocery store. Consequently, other foods such as frozen berries that replace fresh berries or the substitution of farm animal meat that replaces venison may be considered examples of food deviation. The Tsleil-Waututh source of food, identiified as Salmon, may be purchased in limited quantities for consumption or gathered outside of the Tsleil-Waututh

territory but does not provide the people with its original source of nutrition because consumption is reduced to a state of luxury food.

The data presented by the Tsleil-Waututh involves the life histories and experiences of three generations of this First Nation. Each generations' life experiences change over time with changes being influenced by the evolution of Canadian society itself and in relation to the internal empowerment of Canadian Aboriginal communities. For example, the change in education of the people from the Residential school system to the Canadian public education at a local elementary school. The internal empowerment of First Nations people is explained by the respondents change in life experiences from the Depression and World War of the Old people to cultural identity crises of the Adults. Both the Old people and the Adults allude to the policy of the Indian Act in relation to health care when they use phrases such as 'of that era' or 'during that time'.

All respondents are related either by blood, marriage or share a special relationship such as godparents and godchildren that influences their inter-personal, familial and community relationships. The Old people of this community are the source of knowledge of their tribal history, customs, traditions and practices. They are in the process of passing this responsibility over to the Adult generation. This information is provided either to the Old people's children,

nieces, nephews or the information is shared among cousins and practised at both the family and community level. The Adults begin to internalize and practice their sense of Tsleil-Waututh nationhood by the way they conduct themselves on a daily basis. They begin to instruct the Young Adults in an inconspicuous manner. The Adults impart the information or what is commonly referred to by Aboriginal people as teachings received from the Old people.

These teachings are relayed in many forms usually as a story that contains a particular message concerning respect, love, greed, jealousy, etc., all related to promoting harmony between the individual, family, community and universe which in essence is health. The teachings also include the proper Aboriginal social behaviour or the proper way to maintain health such as diet or the proper interaction between the individual and her/his world. The Young Adults are familiar with their history but are in their developmental stage of Aboriginal life that prepares them for their future position where they will possess tribal responsibility within this community as an Old person or an Adult. They receive teachings in story form that provides direction and guidance from the Adults and Old people.

Definitions

Health as defined by the Tsleil-Waututh is a state of well being which may or may not include a disease or sickness. Within this state of health the individual possesses power to control the situation with or without pharmaceutical assistance. Health may or may not include the use of Aboriginal pharmaceuticals, European intervention and pharmaceuticals or a combination of both perspectives dependant upon the individual's experience and definition of the unhealthy condition as a disease or sickness. The fundamental key to health maintenance is prayer combined with family and community support.

Sickness as defined by the Tsleil-Waututh is a state of being that may or may not include a disease. A Tsleil-Waututh sickness may or may not include physical pain that is manageable or controllable by the individual. Sickness is a state of imbalance that the individual possesses power to control and more importantly the power of choice of intervention. Intervention may or may not involve use of either Aboriginal, European pharmaceuticals, or both, that assists the individual to manage or control the pain or unusual symptoms of the unhealthy condition. The severity of pain or unusual symptoms as experienced by each individual determines the appropriate selection of treatment. However,

the presence of prayer and family and community support remains consistent.

Disease as defined by these people is a state that involves unmanageable physical or emotional pain and it may or may not possess uncontrollable symptoms such as bleeding. The state of disease removes the individual from their position of power over the state of imbalance. The distress of the condition extends beyond the individual and affects the harmony of the family and community. The selection of treatment includes Aboriginal and European interventions and pharmaceuticals. The consistent ingredient for management of the condition is prayer combined with family and community support throughout each generation.

Treatment as defined by these people does not include search for a cure but does require search for intervention that assists the individual to manage or control the unusual symptoms that are either physically or emotionally pain related. Treatment includes use of either Aboriginal, European or a combination of both interventions, and pharmaceuticals which all together constitutes home remedies. The use of Aboriginal pharmaceuticals occurs instinctively without the practice of ritual, tabu or ceremony by the individual. The use of Aboriginal pharmaceuticals occurs similar to situations where most Canadians will use a tylenol for a common headache. Aboriginal pharmaceutical use is most commonly prescribed and instructed by the older generations of

the Old people or the Adults either for themselves individually, one another or the younger generations.

Clinical intervention from European practitioners and pharmaceuticals is sought for the treatment of conditions that limit the individual's power to manage or control the unhealthy condition either individually or with the help of the family or community. European clinical intervention is used alone for a condition that causes the individual to exhaust all home remedies without the sought after restoration of the individuals' original state of health.

The Old People

The Old people of this First Nation did not possess a definition of health. Within the interview process itself the question of health presented itself as an oxymoron. It is understood and accepted that with time the body will deteriorate as with all of creation such as plant life. Therefore, unhealthy conditions within the aged body are expected but are not necessarily regarded as a disease or sickness rather the unhealthy condition is considered a condition of life itself. This definition assists to explain why the two cases Parkinson's disease or the incidence of either visual or hearing impairment among the Old people are not recognized by the affected individuals as health care crises.

With the exception of tuberculosis and gout the majority of medically labelled disease present within this segment of the Tsleil-Waututh are not recognized as such. The explanation provided for the recognition of tuberculosis as a disease is the fact that tuberculosis had reached epidemic proporations among First Nations people and that treatment for this particular disease was provided with Legislative force, such as a Health Order in Council issued by the Indian Agent or another European government authority. Gout is recognized as a disease by the individual because of the severity of pain related symptoms and due to the fact that the pain cannot be managed or controlled by either Aboriginal or European pharmaceuticals.

The Old people could not explain the origin of childhood diseases, e.g. chicken pox, measles, whooping cough, etc. among the Tsleil-Waututh. Nor could they determine at what point in their history childhood diseases reached a stage of normalcy within their population. The Old people however did agree that childhood diseases did not affect their population at an epidemic rate and that preventative measures (innoculation) could be acquired from European interventions.

Causes of sickness and disease among the Old people are related to deviation in diet, changes in the environment or a combination of both.

TABLE 4
The Old People

UNHEALTHY CONDITON	DEFINITION	CAUSE	TREATMENT
allergies	sickness	change in environment	western pharmaceuticals Prayer
bowel disorder	sickness	change in diet	western pharmaceuticals Prayer
colitis	sickness	change in diet	western pharmaceuticals Prayer
diabetes	sickness	change in diet	western pharmaceuticals Prayer
gallbladder	sickness	change in diet change in environment	western pharmaceuticals and intervention Prayer
gallstones	sickness	change in diet change in environment	western pharmaceuticals and interventions Prayer
high blood pressure	sickness	change in diet	western pharmaceuticals Prayer
kidney problems	sickness	change in diet change in environment	western pharmaceuticals and interventions Prayer
pneumonia	sickness	change in environment	western pharmaceuticals Prayer

TABLE 5
The Old People

UNHEALTHY CONDITON	DEFINITION	CAUSE	TREATMENT
asthma	developing into a disease due to the increase of incidence among the Tsaleil-Wathuth	change in environment	limited use of Western pharmaceuticals Prayer keep doors and windows closed
cancer	disease	unknown	unknown
gout	disease	change in diet change in environment	western pharmaceuticals Prayer
tuberculosis	disease	unknown	western pharmaceuticals and interventions Prayer

The Adults

The Adults' definitions of childhood diseases remain consistent with the Old people's definitions as normal unhealthy conditions, utilizing preventative measures compatible with the Old people's definition. Explanations for the origin of childhood diseases were not provided.

Alcohol and drug (either prescription or street) abuse is defined as a disease and all other unhealthy conditions are considered to be characteristics of this disease except for congenital disorders. The cause of unhealthy conditions is reported primarily as stress-related. The behaviours of stress such as withdrawal from family or isolation is viewed as the symptom of the unhealthy condition.

A significant variable found among the Adult population that is absent from the Old people is the presence of a congenital factor of certain unhealthy conditions such as stroke or high blood pressure. The actual definition of the unhealthy condition remains consistent with the Old people's definitions of a sickness rather than a disease. No explanations were provided to explain the origin or cause of such unhealthy conditions rather the existence of such conditions is explained as something that is inherited from parents. It is expected then that unhealthy conditions experienced by the parents may be inherited by the children.

TABLE 6

The Adults

UNHEALTHY CONDITON	**DEFINITION**	**CAUSE**	**TREATMENT**
arthritis	sickness	unknown	western pharmaceuticals Prayer
heart attack	sickness	hereditary	western pharmaceuticals and interventions Prayer
stroke	sickness	hereditary	western pharmaceuticals and interventions Prayer
kidney stone	sickness	unknown	western pharmaceuticals and interventions Prayer
high blood pressure	sickness	hereditary	western pharmaceuticals Prayer

TABLE 7

The Adults

UNHEALTHY CONDITON	**DEFINITION**	**CAUSE**	**TREATMENT**
alcohol abuse	disease	stress	Aboriginal Treatment Centre Prayer
drug abuse	disease	stress	Aboriginal Treatment Centre Prayer family and community support
stress	disease	change in environment sense of powerlessness	unknown
depression	disease	change in environment sense of powerlessness	unknown

The Young Adults

The Young adults' definition of childhood diseases remain consistent with the Old people and the Adults' of normal, expected and treatable conditions primarily through preventative measures such as immunization. Definitions of the diseases of alcohol and drug abuse remains consistent with the Adults' with a slight deviation regarding treatment. Treatment involves prayer combined with family and community support in addition to treatment provided outside the community. This treatment involves services provided by Aboriginal controlled treatment centres that focus on culturally based healing practices.

TABLE 8

The Young Adults

UNHEALTHY CONDITON	DEFINITION	CAUSE	TREATMENT
alcohol abuse	disease	unknown	Aboriginal Treatment centre Prayer
cancer	disease	unknown	western pharmaceuticals and interventions
diabetes	developing into a disease due to increase of incidence	unknown	western pharmaceuticals Prayer
gallstones	developing into a disease due to increase of incidence	unknown	western pharmaceuticals and interventions
gallbladder	developing into a disease due to increase of incidence	unknown	western pharmaceuticals and interventions
stroke	unknown	unknown	western pharmaceuticals and interventions
heart	unknown	unknown	western pharmaceuticals and interventions
eye disorder	unknown	unknown	western pharmaceuticals and interventions

Experiences with Surgery

Surgery as reported by the Tsleil-Waututh presents a phenomenon because a relatively high rate of surgery was reported given the population of approximately two hundred. For example, of the fifteen respondents interviewed only one male old person and one male adult did not report an experience with surgery. Surgery occurs as a result of accidents, occupational injury and for symptoms related to pain or abnormal conditions that are not treatable or manageable by the individual's methods of health care. For example, the unhealthy conditions of gallbladder or gallstones is considered a pain-related condition that requires surgery after the individual has depleted all home remedies. Incidents of surgery include appendectomy, tonsillectomy, bowel disorder and kidney stones.

Although incidents of surgery for appendicitis, tonsillitis and kidney stones were reported as occurring with a decline compared to previous incidents, the fact that such health care crises exists warrants reference. In addition, given the influence of diet and changes in the environment in relation to cause of unhealthy conditions for the Tsleil-Waututh's definitions of health, sickness, disease and treatment incidents of surgery presents itself as an important phenomenon. Unfortunately, its relevance was not investigated within this particular study.

CHAPTER XI

SUMMARY AND CONCLUSIONS

The natural citizens of the Burrard First Nation possess a variety of health care experiences and practices. The historical changes, especially the process of colonization within their society, influences their selection of particular treatment interventions. The decision of the Tsleil-Waututh grandmother to relinquish her power and practice devote Catholicism, influences contemporary practices, combined with the influences of Catholicism and Residential school education, her descendants (e.g. the Old People and Adults) have learned to operate the natural Tsleil-Waututh health care system with the absence of Aboriginal ceremony, ritual or tabu.

The succession of Aboriginal health care practices was further enhanced legislatively by the policies of the Indian Act which outlawed Aboriginal ceremonies in Canada. Contrary to the purpose of the design of the Indian Act, from an Aboriginal perspective, the Act was intended to perform an administrative function for the contents of Indian Treaties and not the actual end result of the colonization of Indian societies. The Indian Agent possessed total control over the lives of Indian people. As Bolaria and Li 1985 document:

> This Act was a mandate for government administrators to control the lives of Natives....defined who was an Indian....who was entitled to government [Treaty] benefits....placed restrictions on Native people....[who] could not own land [or] develop it without the agent's consent, could not hold or attend large gatherings [such as the Potlatch or Sun Dance ceremonies]....continues to

> regulate every aspect of the lives of Native people....the effects are devastating for personal autonomy, and group morale, as well as for traditional Native political and social organization (p.37).
>
> The prohibition of large gatherings, for example, the Potlatch and Sundance ceremonies, dismembered the health care practices of the Aboriginal societies because of the incorporation of their type of theology into their natural health care system (p.39).

In addition, the federal policies created under the Indian Act to provide for the health care needs of Indian people, further victimized these societies. Tuberculosis had reached epidemic proporations among First Nations people in Canada, it can be guestimated during the 1930's to the 1960's. However, the Indian agent possessed and used the power to quarantine people and to legally institutionalize First Nations people in sanatoriums resulting in medical colonization.

Changes in the health care policies of the Indian Act are present among the Tsleil-Waututh. These policies refer to choice of doctors, location of doctors and services received with a noted change in policy occurring in approximately 1965. According to the Penner Report (1983), the Department of National Health and Welfare currently exercises responsibility for health services for Indians. In 1979, this department began a gradual process of devolution to the Band (First Nation) level. Prior to 1979 responsibility for health care services for Status Indian people was provided by federal medical facilities with a gradual transfer to provinces to provide hospital services through the provincial hospitalization system with no exact date provided.

The experience in changes of health care service policies for Indian people appears to differ in change from province to

province. As Manuel (1974) points out, during the 1940's in British Columbia the Indian agent attempted to eliminate the government [Treaty] benefit providing health care services: "It was the new policy of the Department that any Indian with a job should pay his own medical expenses" (p. 106). Furthermore, because such policies are externally created and implemented as Adams 1975 states: "Many Metis and Indians know nothing about the government institutions and agencies that control their lives" (p.156).

Health occupies its customary position within the Burrard First Nation in which the state of harmony within the individual is dependant upon her/his relationship with the Creator, family and community. The people's experiences of the unhealthy condition of sickness is defined as dependant upon the amount of power the individual possesses to control or manage the unhealthy condition. The unhealthy condition of a disease is also dependant upon the individual's power to control or manage the symptoms of the unhealthy condition. Restoration of health or treatment for either unhealthy condition does not search for a cure but rather the cause. It is the cause of the unhealthy condition of either a sickness or a disease that is treated. Cause is attributed to changes in the diet, environment or stress. In situations where the direct cause cannot be treated, for example, environmental pollution, the individual searches for methods that provide the power to manage or control the cause.

Prayer, combined with family and community support, is the fundamental key to restoration of the individual's state of health. Treatment includes the use of either Aboriginal or

Western pharmaceuticals and may include a combination of both, called home remedies. Aboriginal pharmaceutical use does not utilize ceremony, ritual and tabu, with western intervention being sought after the individual has exhausted all home remedies. Selection of a particular treatment is based on custom, tradition and the impact of experiences related to federal policy provisions.

The natural citizens of the Burrard First Nation possess a variety of health care experiences and practices. The historical changes, especially the process of colonization within their society, influence their selection of particular treatment interventions. The impact of the arrival of the epidemics of European diseases continues to possess a present moment experience for these people with the results being the dichotomy of disease: "white man's disease" and the normal, acceptable (childhood) diseases. That is, there are certain diseases that are viewed exclusively as a "white man's disease". The evolution of such diseases in relation to the genetic changes in Indian people, for example, cancer, in terms of when and how Indian people become infected, is not considered. This lack of information within their belief system can create future health care crises especially when considering the phenomenon of the Acquired Immune Deficiency syndrome in contemporary society. When a European disease does possess the power to contaminate Indian people, the cause for such infections is related to changes in diet and the environment.

CHAPTER XII

FURTHER RESEARCH AND IMPLICATIONS FOR SOCIAL WORK PRACTICE

During this research project's investigation it became apparent that primary research concerning the Federal policies of health care services provided to Status Indian people is limited to the investigation of Culhane-Speck (1987). The federal policies of the Indian Act in relation to the health care practices and experiences of First Nations citizens in Canada requires documentation. Both Aboriginal and non Indian people need to understand how the colonization of First Nations citizens by the Indian Act contributes to their choice and participation in health care services provided within each province of Canada.

This type of investigation would include focus of Health Orders in Council directives of the Indian Agent with the progression of changes in services and policies of the Indian Act. Specifically: - When and why one policy would cease to exist and what type of policy would replace it?

- At what point in history did the Indian Agent lose his power to quarantine Indians?

- And at what point in Indian/white relations in Canada did the federal government transfer its fiduciary health care responsibilities to the province and what was the impact on Indian people?

With regards to the Tsleil-Waututh unhealthy conditions of stress and depression phenomenon, it is suggested that this health care crisis be investigated culturally. For example, as

the Tsleil-Waututh have explained they continue to converse with the animals. Culturally, this is a socially acceptable behaviour of Indian people. However, for Euro-Canadian people such behaviour may be assessed as delusional which may result in misdiagnosis for the Indian client. When the unhealthy conditions of the Tsleil-Waututh are contemplated in relation to the prevalence of stress and depression, the significance of asthma, allergies or bowel disorders need investigation. The question that presents itself is: Are these conditions the exclusive result of change in diet and the environment or are these conditions related to stress and depression given the colonized state of Indian people that promotes powerlessness and a sense of hopelessness? Secondly, if the stress and depression as experienced by Indian people is a cultural health care crisis, what is the role of alcohol and drug abuse?

In regard to the social work profession and First Nations citizens in Canada, Indian people mistrust the social work profession in general because of past experiences that are viewed by Indian people as cultural genocide. The task at hand for the social work profession is first to create a catalyst situation for Indian people. A relationship that recognizes the strengths of the Indian family, community and utilizes the resources of their environment, thereby laying the foundation to build trust (Ross, 1992, p. 46-47; Falconer & Swift, 1983, ch. 16). A trust relationship that is built upon the goal of empowerment for Canadian First Nations will provide non Indian social workers (and researchers) with the entry point to investigate the health

care issues that may or may not influence the utilization of western provision of health care services and interventions.

Also, it is suggested that therapeutic intervention must be provided in an active form--taking a pill is simply not enough for the Aboriginal client. Changes in diet, exercise, dialogue, preventative health care measures and participatory, family integrated home care are all active prescriptions that the Aboriginal person requires.

It is known that traditionally, Aboriginal practitioners did provide psycho-therapeutic intervention that healed not only the body but the mind as well. Part of the Aboriginal practitioners' intervention method concentrated primarily on discussion of empathic feelings in story form as related to the Indian patient's experience. Contemporary Euro-Canadian intervention needs to adapt its intervention to this type of therapy with oratory exchange occurring by perhaps sharing similar experiences such as poverty, gender issues and child birth.

With regard to the process of gathering medical history or information required for social work intervention, it is recommended that a series of interviews occur in order to acquire a total picture. It must be recognized and accepted by the non Indian social worker that, initially, there will be a feeling of apprehension in regard to the social work professions' relationship with First Nation's people due to past social work culturally inappropriate intervention of the Sixties Scoop. This needs to be acknowledged by the social worker/health care practitioner because it will communicate to the Indian person the social worker's personal commitment and respect within the

therapeutic relationship. The social worker must work to allow the Indian client to educate the social work profession of the reality of Indian life.

Secondly, it requires time to recall incidents of illness/disease/surgery which may be relevant to intervention. More significantly, however, the non Indian social worker must consider that Indian etiquette requires time to consider the question asked before responding, as a matter of respect and that prolonged silence is part of this etiquette. Therefore, in order to assist in closing the cultural gap between Indian and non Indian people, observance of Indian etiquette will assist the non Indian social worker with building a trust relationship with the Indian client.

During the interview process of this research project it became evident that when asked an open-ended question, people would respond instantly with either a yes or no. Part of the explanation of such responses includes two separate issues. First is the question of power that is present within a colonized society. Although the social worker herself is a First Nations citizen, respondents possessed the unspoken question of power. The Researcher had to reassure the respondents that she personally held no power or control over any part of their lives. Second is the process of recollection, that is, the time required to remember based on the Aboriginal concept of time, that being events occurring during a relative's life. During the process of recollection, however, people would remember a particular incident based on the influence of recalling a particular time of their life.

Questions of inquiry therefore should possess the connotation of possibility rather than absolute. That is, the question should be asked in a manner that encourages the client to remember. For example, the question should attempt to illicit the impact of the topic of investigation, collectively, the history of the topic within the family of the client, and the origin of the topic of investigation. This is particularly relevant in relation to the disclosure of what can or cannot be discussed publicly: the interview. The interview, regardless of the style e.g. completion of an assessment form, medical history, etc., is a public forum for the Indian client. The interview, is not recognized as a confidential setting by the Indian client nor is it accepted as a private environment. The Indian client's concept of the interview is a public forum because the Indian client realizes the information will not remain solely with the social worker. It is understood that the information will be shared by the social worker with other people such as the doctor, lab technician, etc. Therefore, until the trust relationship is established the information the Indian client may provide will be limited and vague.

Finally, it must be accepted that until the Indian client and the non-Indian social worker/health care practitioner establishes a level of trust, of a human quality with the Indian person, closed responses will occur. The process required to build and maintain trust with the Aboriginal client will be demanding for the non Indian social worker as with other 'difficult or hard to reach' clients. After years of colonization by non Indian people, the question that the

Aboriginal client will be pondering is: why should this white person be any different?

For social workers who find themselves engaged with Indian groups or communities it is suggested that the primary focus of social work intervention be empowerment, because of the disempowering impact of colonization. In terms of creating change within groups or communities, community development skills are a must and the role of the social worker must be a facilitator, to assist by providing instruction with acquiring resources, especially financial resources, in order to begin building towards the economic stability that is needed in Indian communities. For example, instruction in how to prepare a proposal to access funding dollars. The need for such social work intervention is based on the fact that most Indian communities are subject to external control of finances by the Department of Indian Affairs or another government department. It is fact that there exists a lack of long-term economic activity On-Reserve. A majority of Canadian Indian people possess low levels of Western education. Within First Nation communities there exists a high level of poverty found within most Aboriginal groups and communities. The resolution of this type of disparity requires verbal encouragement and visual instruction by the social worker for the Indian clients who need to acquire new skills.

Community care, as demonstrated by the people of Alkali Lake, for example, requires that the social worker exchange dialogue to examine what is an asset and what is a liability within the community. Adoption or adaptation of the Aboriginal

community resources either human or material as Ross (1990) documents, will also be required but the decision of which and how is the responsibility of the people and not the social worker. The social work role should always remain as facilitator. The philosophy of social work intervention requires a committment to consistent demonstration combined with dialogue and the exchange of participatory practice, with the guidance of the social worker.

This research project demonstrates that the colonization of First Nations people in Canada influences the health care choices that they select or do not select. The dichotomy of disease is extraordinarily important given the fact that there does exist the ideology among Aboriginal people that certain diseases belong exclusively to European people and that participation in the theological component to ceremonial healing is restricted to Aboriginal people. Social work health care interventions must concentrate on the social work value of the right to self-determination. Explanations for the selection of a certain social work intervention strategy must also concentrate on the human doctrine of respect which includes working with the resources of the person and their identified family and community. However, in all situations the establishment of a human relationship built upon mutual respect, autonomy and respect is paramount.

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