

Family health and parenting in an urban Inuit community

Kelly McShane

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ABSTRACT

Family health and parenting in an urban Inuit community

Kelly McShane, Ph.D.
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There has been little research examining urban Inuit health, despite significant health disparities and indications that Inuit perspectives on health differ from mainstream perspectives. This collection of studies examined family health and parenting in an urban Inuit community and employed a participatory action research approach in partnership with the Tungasuvvingat Inuit Family Resource Centre.

The first study examined health information processes through key informant interviews and focus groups. Five themes emerged: importance of visual learning, community Elders, and cultural interpreters; community cohesion; and an Inuit and non-Inuit distinction. The core sources of health information were family members and sources from within the Inuit community. The principal dissemination strategy for health information was one-on-one communication. Overall, results showed a community-specific perspective on health information.

The second study developed and evaluated a health promotion tool tailored to the community's preferences articulated in Study 1. A CD-Rom presented an Inuk Elder delivering two messages on supporting mothers during pregnancy. Quantitative and qualitative measures were used to assess participants' expectations and reactions to elements of the CD-Rom. Quantitative analyses found increases in evaluation, medium, and content ratings. Qualitative findings included: (i) interest, uncertainty, and conditional interest prior to viewing; and (ii) positive evaluations of the CD-Rom (in particular of the Elder) and an interest in additional similar tools on parenting topics from

a family-centered perspective. Taken together, results suggested that the tool is appropriate for this community and that Inuit health is family-based.

The third study further examined urban Inuit parenting by using the autonomy-relatedness perspective from cultural psychology, in order to increase understanding of how parents support the well-being of their children. Major parenting themes obtained from interviews included: child characteristics, parenting behaviours and beliefs, affection and love, stressors, and responsive and respectful parenting. The majority of parenting themes linked to relatedness, although there was evidence of autonomy in both parenting behaviours and child characteristics.

Overall, research findings emphasized the family perspective on health held by this Inuit community, and pointed to differences in health information structures and parenting as a result of living in an urban context. Implications for health research and health promotion are discussed.

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Contribution of Authors

Statement on Research Team Members:

The research described in this doctoral dissertation was based on an academic-community partnership with the Tungasuvvingat Inuit Family Resource Centre. The Academic Research Team comprised the doctoral student (McShane), her supervisors (Smylie, Hastings), researchers involved with the larger project directed by Smylie (only one of whom was involved in the dissertation; Martin who is a co-author on Study 1) and a research coordinator (Prince). The Community Research Team comprised the senior manager of the Tungasuvvingat Inuit Family Resource Centre and two front-line staff. As this work follows a participatory action research approach, the core team (McShane, Smylie, Hastings, and the senior manager of the TIFRC) were involved in decisions concerning the logistics of conducting community-based research. McShane conceptualized the results of Study 1, although the study's research questions were identified by Smylie and the community research team. Across Studies 2, and 3 McShane assumed a role of leader of the academic research team and worked with the core team to identify the research questions to present to participants based on her conceptualization of the two studies. McShane coded the data from all three studies and Martin and Prince acted as the reliability coders for Study 1, and Study 2 and 3, respectively. McShane interpreted the findings, with community-based clarifying from the senior manager of the TIFRC as needed. The senior manager of TIFRC read the dissertation to provide community feedback for publication. Finally, the written text of this dissertation is an original piece of work by McShane.

Literature Review Contained in General Introduction (Presented in full in Appendix A):

Original Reference

McShane, K. E. & Hastings, P. D. (2004). Culturally-sensitive approaches to research on child development and family practices in First Peoples communities. *First Peoples: Child and Family Review*, 1(1), 33-48.

This manuscript was based on a fellowship proposal written by McShane. Hastings provided supervision on the writing of the manuscript.

Study 1: Original Reference

McShane, K. E., Smylie, J. K., Hastings, P. D., & Martin, C. M., & Tungasuvvingat Inuit Family Resource Centre (2006). Guiding health promotion efforts with urban Inuit: A community-specific perspective of health information sources and dissemination strategies. *Canadian Journal of Public Health*, 97, 296-299.

This manuscript was written by McShane. Smylie and Hastings provided supervision for the writing of the manuscript, and Connie Siedule of Tungasuvvingat Inuit Family Resource Centre provided feedback on the manuscript. The original research program and questions were developed by Smylie, and elaborated on by McShane. Thematic content was identified by Smylie, and coded by McShane and Martin. Structuring and interpretation of the results was completed by McShane and Hastings. The project was completed in collaboration with Tungasuvvingat Inuit Family Resource Centre.

Introduction

In the 2001 Census, 976,305 people reported Aboriginal identity (3.3% of the total Canadian population), with 608,850 (2.1%) identifying themselves as First Nations, 292,305 (1%) identifying themselves as Métis, and 45,070 (0.2%) identifying themselves as Inuit (Statistics Canada, 2001a). The Inuit population has increased by 12% from 1996 to 2001. The Inuit population is the youngest in Canada; with a median age of 20.6 years for Inuit, compared to a median age of 37.7 years for the general Canadian population. The Inuit population is also younger than both the First Nations and Métis populations. In 2001, nearly 40% of the Inuit population was under the age of 14. Not only are there differences in the demographics between the various Aboriginal groups, it is important to recognize that Inuit, First Nations, Métis and each have unique cultures, heritages, socio-economic, and geographic contexts (Smylie, 2000b).

Unlike other Aboriginal groups, imposition of Western culture on Inuit did not occur until the mid-twentieth century. Consequently, Inuit have a distinct infrastructure capacity when compared to other Aboriginal groups. This is particularly evidenced by the only recent declaration of Nunavut as an Inuit territory in 1999 (Government of Nunavut, 2006b). At present, Inuit live in four land claim regions with fractured jurisdictional responsibilities split between various provincial, territorial and federal governments (Ajunnginiq Centre, 2006). The majority of Inuit live in northern communities located across Labrador, Quebec, Nunavut, and Northwest Territories; and the vast majority of these communities are accessible only by air (Inuit Tapiriit Kanatami, 2004). Isolation limits access to health services at community levels and significantly increases the costs of accessing regional and provincial health services.

Researchers and practitioners have studied health care delivery to Inuit in the north (Archibald & Grey, 2000; Thouez, Foggin, & Rannou, 1990). However, an increasing trend towards urbanization by Aboriginal peoples has resulted in 25% of Inuit living in urban areas, predominantly in Iqaluit, Yellowknife, Edmonton, and Ottawa (Statistics Canada, 2001b). The Inuit population in Ottawa is reported to have increased five-fold in 20 years (Roy-Sole, 2005). Urban Inuit health is an understudied area; little is known about Inuit who are living in urban areas and potentially are able to access local health care services. Regrettably, there is little evidence that changes have taken place in health organizations to better serve the changing population of Inuit as there is a paucity of urban Inuit health initiatives among national stakeholders in Inuit health (Young, 2003).

Overview of Studies

This collection of studies examined the health of urban Inuit. In keeping with the Inuit traditions, health was viewed as family-centered and was conceptualized from a wholistic¹ perspective; including physical, mental, emotional, and social; and across individual, family and community levels. Inherent in such a perspective is the recognition of the importance of family and community in determining an individual's health, such as has been recommended in a series of policy statements concerning Aboriginal health (Smylie, 2000a). Consequently, this research was community-based, and sought to understand one unique community rather than applying any pan-Aboriginal, pan-urban or even pan-Inuit models of health. This community-specific process was deemed necessary as it is the only means by which to accurately capture the uniqueness and subtleties of the

¹ Wholistic is used in place of *holistic*. As suggested by Amelia McGregor (2004), wholistic is rooted in the word *whole*, considered an accurately representative of the true meaning of this adjective.

Inuit community of Ottawa. Research materials and evaluation tools were developed to be consistent with Inuit learning styles, so as to ensure cultural validity. Furthermore, the research involved a partnership with Tungasuvvingat Inuit Family Resource Centre and followed a participatory action research approach.

Participatory action research (PAR) was used to approach the research questions as it is considered the most appropriate approach to use when conducting research with Aboriginal communities (Fletcher, 2003; Inuit Tapirisat of Canada and Nunavut Research Institute, 1998). The PAR approach aims to balance the power relationships between community partners, community participants, and the academic research team throughout all phases of the research process. The current project brought together a set of academic research team members and community research team members, including the senior manager and two frontline health workers from the partnering organization (Tungasuvvingat Inuit Family Resource Centre). The community was first approached by the senior academic research team member and a partnership was established and a community research agreements was negotiated and used to steer the research project at large (Smylie, McShane, & Tungasuvvingat Inuit Family Resource Centre, 2006).

Family health and parenting formed the broader research focus. The overarching goal of the research program was to document family health and parenting in the urban Inuit community of Ottawa. The first study aimed to identify the community-specific perspective on health information sources and dissemination strategies. The second study used this community-specific information to develop and evaluate a locally-tailored and culturally-congruent health promotion tool. Given that the partnership was with the Tungasuvvingat Inuit Family Resource Centre, the tool focused on maternal well-being

during pregnancy. Building on the family health focus, the third study examined how parents support their children's health and well-being. The goals were to document the features of parenting by urban Inuit and to examine how existing cultural psychology theories of parenting can be used to characterize urban Inuit parenting. Together these studies explored urban Inuit health and well-being and furthered our understanding of urban Inuit family health and parenting.

Health and Well-being of Inuit

Like other Indigenous populations, Inuit possess very strong kinship networks (Penney, 2004). Inuit culture is strong and resilient, and Inuktitut is one of the very few Aboriginal languages that is not in danger of extinction (Inuit Tapirisat of Canada, as cited in Smylie, 2001a). In fact, 70% of Inuit can converse in Inuktitut (Ajunniginiq Centre, 2006). Inuit also have a strong understanding of the environmental changes in the arctic (Ferguson, Williamson, & Messier, 1998), and played a pivotal role in the proceedings of the United Nations Climate Change Conference held in 2005 (Inuit Tapirisat of Canada, Nasivvik Centre for Inuit Health and Changing Environments at l'université de Laval, & Ajunniginiq Centre at the National Aboriginal Health Organization, 2005). Inuit Elders also possess a wealth of knowledge of traditional medicines and techniques for treating numerous medical and psychological illnesses (Bennett & Rowley, 2004; Gray, 1996).

Despite their extensive knowledge of illness and disease, Inuit in the northern regions of Canada experience significant and persistent disparities in health status compared to the rest of the Canadian population (Health Council of Canada, 2005; Nunavut: Department of Health and Social Services, 2002; Pauktuutit, 2002). In

Nunavut, in 1999, the life expectancies at birth for men and women were nine and ten years behind non-Aboriginal male and female populations, respectively (Archibald & Grey, 2000). Infant mortality rates are also markedly elevated for the Inuit compared to the general Canadian population (Archibald & Grey, 2000). Additional health status disparities facing Inuit children, compared to Canadian children, include higher rates of premature birth, low birth weight, respiratory diseases, upper respiratory tract infections, otitis media, hearing loss, meningitis, tuberculosis, and other infections (Ayukawa, Bruneau, Proulx, Macarthur, & Baxter, 2003; Carney & Moeller, 1998; Health Council of Canada, 2005; Hodgins, 1997; Julien, Baxter, & Crago, 1987). In comparison to the general Canadian population, Inuit also suffer from higher rates chronic diseases such as cancer and circulatory disease, and infectious diseases such as tuberculosis and chlamydia (Health Council of Canada, 2005; Pauktuutit, 2002; Statistics Canada, 2001a). Fetal alcohol syndrome/fetal alcohol effects (FAS/FAE) is believed to be a serious problem for the Inuit population, although no reliable data are available at present (Pauktuutit, 1998). Rates of depression and suicide have also been found to be elevated for adult and adolescent Inuit in the north (Kirmayer, Boothroyd, & Hodgins, 1998; Kral, 2003; Penney, 2004).

The health and well-being of Inuit has been impacted by colonization (Smylie, 2000b). Much has been written on the impact of colonization on First Nations; however, very little has been written with respect to Inuit. Inuit did suffer much of the same oppression encountered by First Nations (e.g., suppression of language, residential schools, domination), although the timing, impact, and mechanisms were likely different for Inuit. For example, Smylie (2000b) suggested that these events have impacted

community building activities such as the sharing and eating together of traditional foods. It is necessary to recognize that colonization has had an impact on Inuit health and well-being, and thus affects this population's health needs and practices.

Urban Inuit. This perspective on health disparities is based solely on those Inuit in the north. At present, one quarter of Inuit in Canada live in urban regions (Statistics Canada, 2001a). Existing published reports of health statistics for Inuit living in urban regions are sparse. Census data provide the number of Inuit living in several metropolitan census areas (Statistics Canada, 2001a) and the Aboriginal Peoples Survey (APS) assesses self-rated health, use of health care services, and chronic disease (Statistics Canada, 2001c). However, both of these sets of statistics are of limited utility in understanding the health of urban Inuit. The census data do not provide information about health, and oftentimes the estimates of population counts for urban Inuit are flagged as needing to be interpreted with caution because the transient nature of the urban Inuit population results in underestimates of urban counts. For instance, although the 2001 Census reported the Inuit population in Ottawa to be 450, recently published community reports numbered the community size at just over 1,000, making Ottawa the largest Inuit community in the south (Roy-Sole, 2005). The APS results for metropolitan areas did not present Inuit-specific information; rather, health results were presented for "Aboriginal" persons generally. Also, the APS measure of 'self-rated' health has yet to be validated in Aboriginal communities, and is considered problematic in the field of population health (Kawachi, Kennedy, & Glass, 1999). Thus, there is currently very little information about the health of Inuit living in urban regions. Urbanization may mean that the health and

health care needs of Inuit are changing (Bjerregaard, 2005). Also, it is unclear how both colonization and urbanization have impacted urban Inuit health.

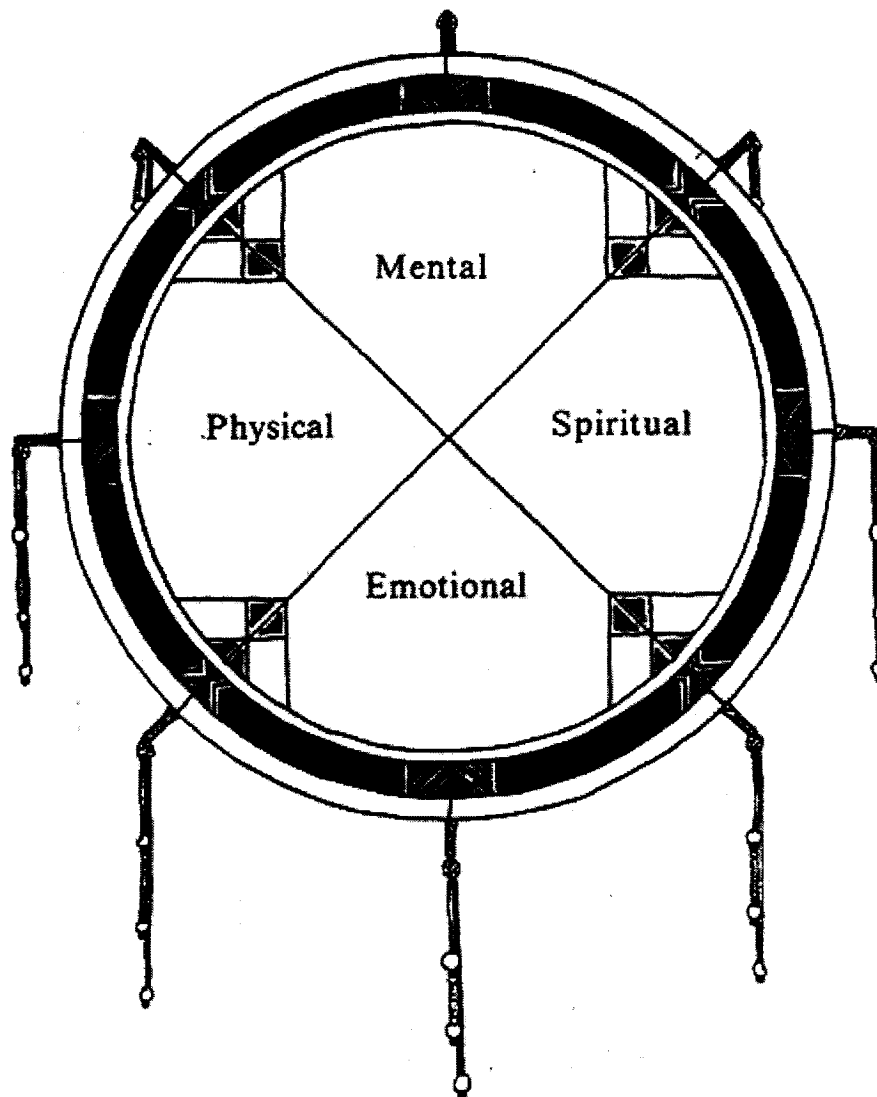
Aboriginal and Inuit Perspectives on Health and Well-being

Aboriginal peoples hold a wholistic view of health (Dufour, 1994; Smylie, 2001b). This means that the whole person is considered in the maintenance of health and wellness. The medicine wheel is a circular paradigm often used by First Nations and Métis peoples as a framework for understanding and teaching about health and life cycles (Smylie, 2001b). Many of these frameworks exist and all are extremely complex and sophisticated. They are presented here in a simplified format to provide a general overview of the prevailing Aboriginal explanations of health. The medicine wheel, from a health perspective, signifies the inter-relationships between mental, physical, spiritual, and emotional elements of health and well-being of both individuals and communities (as depicted in Figure 1). The medicine wheel is also used to capture the life cycles of humans, animals, plants and seasons (see Figure 2). It depicts life through the passage of stages, including infancy, childhood, adulthood, and senior years. Each individual, regardless of stage, is seen as having a gift to contribute to the well-being of the community (Smylie, 2001b).

Inuit conceptions of health are rooted in the Earth or the cosmos (depicted in Figure 3; Dufour, 1994). Accordingly, all elements, including humans, animals, plants, earth, and water are linked by a kinship shared by the stars and the storms. The respect for human and animal permeates relationships at both community and family levels. The self level represents the conception of an ecological self, coexisting with other humans and the cosmos. Disease is seen as a deficient relationship at one level or another.

Figure 1.
Medicine wheel depicting elements of health

The Medicine Wheel

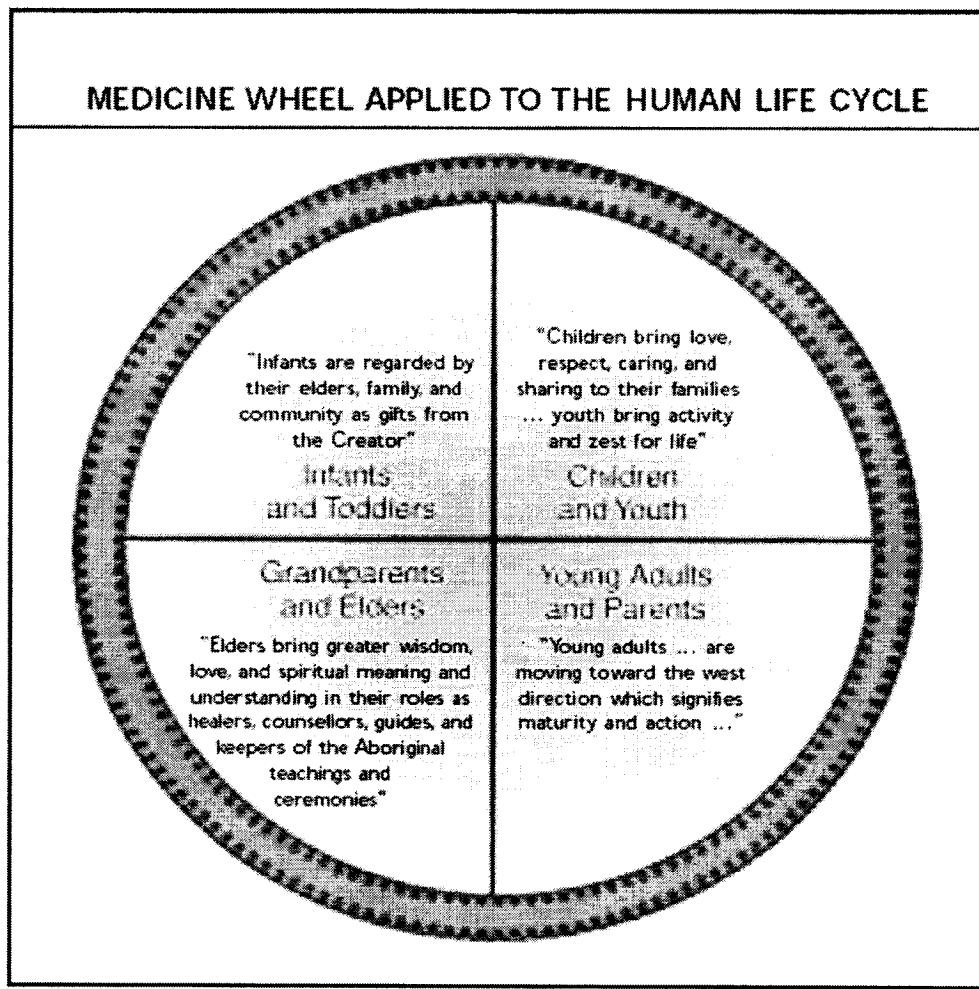


Reproduced with permission from Four World International Institute for Human and Community Development.

Source: Bopp, J., Bopp, M., Brown, L., Lane Jr., P. (1985). *The sacred tree*. Lethbridge, AB: Four World International Institute for Human and Community Development.

Figure 2.

Medicine wheel depicting life cycles

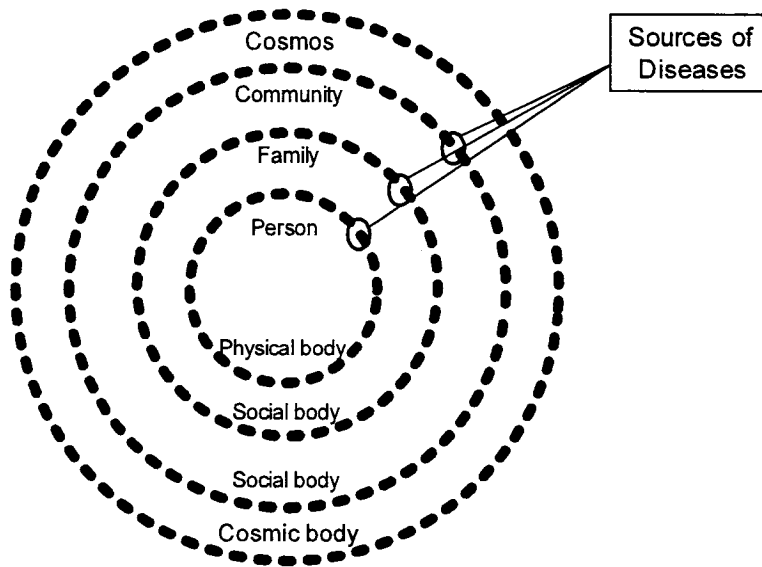


Reproduced with permission from the Society for Obstetricians and Gynaecologists of Canada.

Source: Smylie, J. (2001). A guide for health professionals working with Aboriginal peoples: Health issues affecting Aboriginal peoples. *Journal of the Society of Obstetricians and Gynaecologists*, 100, 1-15.

Figure 3.

Inuit perspective on health and disease



Reproduced with permission from the International Journal of Circumpolar Health.

Source: Dufour, R. (1994). Otitis media as stigma or process: Conflicting understandings from Inuit culture and biomedicine. *Arctic Medical Research*, 53, 669-675.

According to this model, health is seen as being alert in mind, body, and society (Dufour). Thus, the Inuit conception of health is wholistic and proposes a relational model, relational to others and to the environment.

Knowledge systems in Aboriginal communities have also been documented by Aboriginal scholars in Canada, with recent application to the field of Aboriginal health knowledge. A knowledge system is a method of organizing and condensing experience, beliefs, and ways of knowing (Smylie et al., 2004b). Indigenous knowledge is described as ecological, wholistic, relational, pluralistic, experiential, timeless, infinite, communal, oral, and narrative-based (Castellano, 2000; Little Bear, 2000; Malloch, 1989; Shiva, 2000). Smylie et al. (2004b) have further elaborated on the knowledge systems to explain the generation of knowledge and presented a preliminary model for the dissemination of knowledge. This model begins with 'stories', considered the base units of knowledge; proceeds to 'knowledge', which involves the integration of values and processes in the stories; and culminates in 'wisdom', considered an experimental distillation of knowledge. A key feature of the knowledge generation system is that it is cyclical, as 'wisdom' keepers proceed to generate new 'stories'. This model is clearly an oversimplification, and represents a preliminary and elementary attempt to describe a process of Indigenous knowledge dissemination. Smylie and her colleagues propose that health sciences research with Aboriginal communities would thus need to be specifically developed and evaluated in collaboration with Aboriginal communities. Inherent in this proposition is the acknowledgement that health knowledge systems will be community-specific, reflecting Inuit, First Nations, and Métis social, political, and cultural structures.

Comparative Analysis of Inuit and Biomedical Perspectives of Health

Dufour (1994) has noted striking contrasts between biomedical and Inuit models of health and illness. She states that in a biomedical model, the agent-host-environment is considered to be the system of factors responsible for a given disease. Agent refers to the person, object, or chemical responsible for the illness (e.g., microorganism). Host refers to the individual, including his or her characteristics (e.g., genetic make-up, age). Environment encompasses the conditions surrounding the illness, including physical setting, geography, etc. However, given the limitations in understanding the role of the environment in pathology, biomedicine focuses on the individual and his or her physiology. Dufour goes on to state that “The individual is separated from the environment because, on the one hand, environmental data are inaccessible to the clinician and, on the other hand, even when sickness is explained as being related to the environment, action is limited to the symptoms” (p. 669). The biomedical model is thus a mechanist body-centered model, contrary to the Inuit model of health which is relational such that the person cannot be reduced to their physical body alone (Dufour). Another key difference is that health is viewed wholistically by the Inuit, including the physical, social and cosmic environments, whereas health in the biomedical model is generally restricted to physical health.

A growing trend in the health care field has been the inclusion of family in the treatment of ill patients. Although typically it is a spouse or parents of a child who would be involved, researchers have suggested that the definition of family be more inclusive, to accommodate plural family structures (Doane & Varcoe, 2006). In particular for Aboriginal communities, it is vital to recognize that as well as biological parents, grandparents, aunts, uncles, Elders, and other community members are all considered

family members. Such inclusiveness has also been proposed in studying the psychological well-being of Aboriginal children (McShane & Hastings, 2004) and treatment of cancer (Burhansstipanov & Hollow, 2001). As well, a recently proposed model of palliative care of Aboriginal patients in Australia, included a family-centered approach with broad definitions of families. Such a model acknowledged the cultural knowledge and personal authority of family members (Fried, 2000). Thus, there is some suggestion that mainstream models of health and health delivery are shifting to be more closely aligned with Inuit and Aboriginal family-centered and wholistic perspectives on health. However, it is too early to tell how such theoretical suggestions are translating into direct changes in the day-to-day health care experiences of Inuit and Aboriginal.

Unlike Indigenous knowledge, Western science has been characterized as reductionist, linear, objective, hierarchical, empirical, temporal, singular, specialized and written (Duran & Duran, 2000; Little Bear, 2000; Smylie et al., 2004b; Tuhiwai, 2001; Youngblood Henderson, 2000). In Western science, individual data are organized into abstract theoretical systems, composed of many parts, each of which requires a ‘specialist’ to be fully understood. Also, unlike Indigenous knowledge which is cyclical and promotes dissemination, translation of scientific knowledge to the public is not prioritized in Western science (Smylie et al., 2004b). *Knowledge translation* is defined as the “exchange, synthesis and ethically-sound application of researcher findings within a complex system of relationships among researchers and knowledge users” (¶ 3) (Canadian Institutes of Health Research, 2002). Current models of knowledge translation have been developed devoid of cultural context. When knowledge translation activities do occur in Aboriginal communities, there is little adaptation of mainstream knowledge

approaches to provide context-specific and relevant knowledge and dissemination processes (Smylie et al., 2004a). Thus, mainstream health knowledge dissemination is likely incongruent with Inuit and Aboriginal knowledge structures.

In all, this comparative analysis reveals significant differences between Aboriginal and biomedical perspectives on health. There is some suggestion that from a theoretical level, health care models are moving towards family-centered and wholistic models. However it is unclear if and how this has translated into changes at a tangible level. It is also apparent that mainstream knowledge systems and structures are likely incongruent, at an epistemological level, with those of Inuit and Aboriginal communities. In fact, some researchers have suggested that health strategies implemented by governments are often ineffective with Aboriginal communities because the biomedical knowledge frameworks are incongruent with local understandings of health and illness and local mechanisms for sharing knowledge (Smylie et al., 2004b). Thus, at present there appears to be some areas of incongruencies between Inuit and mainstream health perspectives.

Reframing Health Research with Urban Inuit and Aboriginal Peoples²

The health of urban Inuit represents an understudied area, riddled with many questions and uncertain causes for the health disparities between Inuit and the general Canadian population. It is clear that there are key demographic, cultural, and geographic differences between Inuit and the general Canadian population and with other Aboriginal populations. In addition, the above review revealed significant differences between Inuit and mainstream health perspectives. In light of these differences, three principles can be

² Some of the text and ideas presented below (until Study 1) are derived from a previously published article (McShane & Hastings, 2004). The article in full is presented in Appendix A.

identified and implemented in order to understand the family health and parenting of urban Inuit.

Developing community-specific health perspectives. Researchers are beginning to acknowledge differences between mainstream biomedical models and those of Aboriginal peoples. However, it is not sufficient to develop pan-Aboriginal models of health information, as this would disregard the unique social, cultural, linguistic, and geographic features of the Inuit, First Nations, and Métis populations (MacKinnon, 2005). Models need to be developed specifically for each Aboriginal group. Furthermore, there is the need to respect the heterogeneity of Inuit, First Nations, and Métis populations. Recognizing that there are intergroup differences should not be made at the expense of recognition of intragroup differences. Inuit, First Nations, and Métis populations are diverse, comprising approximately 50 culturally diverse groups, with roots related to language and land base (Smylie, 2000b). Additionally, being part of a cultural group does not mean that all individuals subscribe to the specific values and traditions of that culture to the same degree. Accordingly, perspectives should be group-specific, with the recognition that individual group members may identify to varying degrees.

Researchers need to not only acknowledge the cultural identity of the population (e.g., Inuit), but also the larger social context in which the population resides. Some socialization researchers have suggested that the members of different cultural groups living in the same urban area are more similar to each other, than are members of the same cultural group living in rural areas (Garcia Coll & Pachter, 2002). In accord with this, recent research suggests that certain health indicators of Inuit have changed as a

result of migration, and that urban Inuit more closely resemble the larger urban population in Denmark, than the rural Inuit population. Bjerregaard et al. (2002) found that blood pressure among Inuit migrants living in cities in Denmark was higher than Inuit living in Greenland, thereby suggesting differences according to geographic context. The authors pointed out that modernization, and not migration, could be responsible for the change in blood pressure. Nevertheless, this research suggests that it is necessary to consider both cultural and geographic factors when examining the health status of Inuit and other Aboriginal peoples. This further illustrates the unique social and geographic context of Inuit and reinforces the message that Inuit have unique health needs, requiring unique health interventions.

These findings should behoove researchers to focus on not only the cultural, but also on the geographic context of Inuit. Accordingly, a community-specific health perspective will provide the most accurate characterization of Inuit health. Developing community-specific perspectives on health will require the use of an *emic* approach. The *emic* approach focuses on the culture-specific behaviour, customs, values and traditions of a designated culture group. This position has also been described as a *relativist* perspective (Dragnus & Tanaka-Matsumi, 2003). From this vantage point, researchers focus on the scope of cultural variation, the need to understand the unique phenomena within any given culture, and to study cultural groups on their own terms. This perspective is contrasted with an *etic* or *universalist* perspective which looks for universals that are 'true' across cultures and focuses on the differences in levels of certain dimensions and categories across different cultural groups (Dragnus & Tanaka-Matsumi).

Few studies have utilized an emic or community-specific perspective to understand the health and well-being of Inuit. Douglas (1994) assessed community members' experiences and understanding of schooling within an Inuit community as a first step towards recontextualizing the institution of schooling to better reflect the community context. Likewise, Gillis (1992) sought to understand First Nations parents' views about early childhood education prior to suggesting changes to day care curriculum. Based on meetings with parents and observation of day cares, she was able to conclude that First Nations communities supported play as a beneficial activity for children. In a project completed by Pauktuutit, Archibald (2004) interviewed Inuit in both urban and rural communities to gather information on experiences with teenage pregnancy as a formative step in the development and planning of resources for Inuit adolescents. These researchers were able to understand Aboriginal peoples' communities prior to devising and implementing programs. The depth of information gained from this emic approach provided the researchers with the necessary community-specific perspective in order to guide future research.

Culturally-competent measurement of health and well-being. Much of the research conducted with Aboriginal peoples has relied on traditional social science methods of inquiry, including questionnaires with rating scales. Some researchers have questioned the appropriateness of these methods (e.g., Beiser, 1981). These questionnaires were principally developed for use with Western cultural groups in North America and they may not be valid or appropriate for use with other cultural groups including Aboriginal peoples. The content covered in these questionnaires may not be relevant and the wording of questions may contain implicit biases, be unclear, or be

unfamiliar to Aboriginal peoples. The concepts of ratings scales and anchor terms (e.g., *strongly disagree*) have grown out of Western academics' work and may not be typical of Aboriginal peoples' thoughts and perspectives on family health and well-being.

Traditional social science questionnaires should be supplemented (if not replaced) by other information gathering methods that are adapted to better match traditional learning styles, customs and values of Inuit, First Nations, and Métis. For example, narrative approaches may be an ideal method because Aboriginal peoples' culture stresses the importance of conversation (e.g., Carbaugh, 2001).

In addition to measurement tools, concerns have been raised in regards to specific health measures. Smylie et al. (2004a) noted that current infant health measures, including birth weight and infant mortality rates, focus on individual health and may not accurately reflect Aboriginal communities' understanding of health and wellness. Infant mortality is a distressing outcome, but is a rare, future outcome and may be of less relevance to Aboriginal communities who prefer examining more proximal indicators of health. Accordingly, useful and appropriate measures of infant health might instead include rates of breastfeeding.

Additional research suggests that long-standing health risk indicators may lack validity for use with Indigenous peoples. Charbonneau-Roberts, Saudny-Unterberger, Kuhnlein, and Egeland (2005) assessed whether the use of body mass index (BMI), calculated using standing height (traditional method), provided valid estimates of obesity in the Inuit population. The researchers found that Inuit have shorter legs, yet relatively higher sitting heights when compared to all other populations. Thus, their BMI would be disproportionately higher, solely as a result of their shorter legs. Consequently, the

incidence of obesity would be overestimated as a result of the invalid BMI measurement. The researchers suggested that for Inuit, high BMI may not be indicative of obesity, and suggested that calculating BMI using sitting height would provide a more valid estimate of obesity.

Other research has found that associations between factors and outcomes identified in the majority population are not the same in the Aboriginal population. For instance, BMI (as a measure of obesity) is closely linked to cardiovascular disease and diabetes in the general Canadian population (Rabkin, Chen, Leiter, Liu, & Reeder, 1997; Reeder et al., 1992). Researchers assert that a high BMI is considered a risk factor for those diseases. However, research has consistently found that high BMI does not have the same health-related implications for Inuit (Young, 1996a). Regardless of the BMI level, Inuit have lower triglyceride and higher average HDL-cholesterol, when compared to the general Canadian population (Young, 1996b). This suggests that the link between obesity, as measured by BMI, and cardiovascular disease and diabetes is not present for Inuit, or at least that BMI is not a valid measure of obesity, as suggested by Charbonneau-Roberts et al. (2005).

Similar findings have also emerged, although to a lesser extent, for measures of parenting and child well-being. Letourneau, Hungler, and Fisher (2005) found that although First Nations mothers were less verbal in their parent-child interactions, as compared to non-Aboriginal mothers, the overall interaction quality was not different from non-Aboriginal parents. If researchers rely exclusively on parent-child verbal interactions as a measure of overall parent-child relationship quality, then First Nations parents' interactions will appear deficient. However, if researchers recognize that the

communication patterns of First Nations include silences and nonverbal communication (Seidman et al., 1994), then a more culturally appropriate definition and measurement of parent-child interactions can be achieved. Overall, this research suggests that care must be taken in the measurement of aspects of health and the interpretation of factors and health outcomes, so as to ensure that these are valid and appropriate conclusions to make for Aboriginal peoples.

Respectfully engaging with Aboriginal communities. Working with a community is the most culturally-competent approach to research with Aboriginal populations. In this framework for conducting research, communities are involved in an equal partnership with the researchers. This method is called *participatory action research* (PAR) and is defined as “the systematic enquiry, involving collaboration of those affected by the issue being studied and the researchers, for the purpose of education and taking action or bringing about social change” (Green et al., 1995, p. 43). PAR is based on the integration of community members as equal partners; integration of the intervention and evaluation of the intervention’s success; and creation of learning experiences for the program’s researchers and staff, as well as participants. A unique feature of this research perspective is the equal involvement of 3 members: (i) community researchers; (ii) academic researchers; and (iii) the community members. The importance of the PAR process cannot be overstated, as both research outcomes and practical knowledge transfer will contribute to Aboriginal peoples’ acquisition of the information, skills and tools needed to continue advancing their own welfare.

With the shift toward PAR, recognizing and promoting active community participation in research is replacing past research models in which researchers held

exclusive control over the process and the results. Thus, it will be essential to advance a code of research ethics that focuses greatly on confidentiality, avoidance of harm and potential benefits *at a community level*. Correspondingly, the Canadian codes of ethics (e.g., Medical Research Council of Canada, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 1998) and those of Aboriginal peoples groups (e.g., Inuit Tapirisat of Canada and Nunavut Research Institute, 1998) have grown to reflect this sharing of leadership, research design, and decision-making (Macaulay et al., 1998). Similar codes of ethics have been developed for specific partnerships. The code of ethics for the Kahnawake School Diabetes Prevention Project includes a policy statement about the incorporation of a Mohawk perspective into the project, clarification of the roles and obligations of the partners, and guidelines for control of data and dissemination of results (Macaulay et al., 1998). More recently, the principles of OCAP (Ownership, Control, Access, and Possession) have been identified, and advocated for in First Nations research (Schnarch, 2004). OCAP is considered self-determination as applied to research. The principles apply to all aspects of research, surveys, statistics, cultural knowledge, information in general, including its creation and management. In all, there is a growing movement towards the development of community codes of ethics to guide community-based research.

Examining Urban Inuit Health

The principles detailed above were implemented in the current collection of studies examining family health and parenting in an urban Inuit community. Throughout the research, health was seen as family-centered and wholistic, and the importance of

infants and children in the well-being of a community was recognized. The research aimed to develop a community-specific: (i) perspective on health information; (ii) health promotion tool; and (iii) understanding of parenting. By using an emic approach, methods of information gathering and measurement of outcomes were tailored according to Inuit learning styles and community preferences. Research was conducted in partnership with Tungasuvvingat Inuit Family Resource Centre, using a participatory action research approach.

The use of these principles supported the development of a formative perspective on urban Inuit health. As an initial starting point, the first study examined the health information processes of the Inuit community in Ottawa. Specifically, the goal was to understand and document health information sources and dissemination strategies as they naturally occurred in the community. This provided the necessary foundation to develop health promotion programs which capitalize on the existing and successful health information sources and dissemination strategies.

Study 1³

Guiding health promotion efforts with urban Inuit:

A community-specific perspective on health information sources and dissemination strategies

In the 2001 Canadian Census (Statistics Canada, 2001b), 45,070 people (0.2% of the total Canadian population) identified themselves as Inuit. Approximately one quarter of Inuit live in urban areas (Statistics Canada, 2001b). Numerous recent publications have attested to a significant disparity between the health of Inuit, and Aboriginal people in general, and that of the general Canadian population (Jenkins, Gyorkos, Culman, Pekeles, & Mills, 2003; Smylie, 2000a; Smylie, 2001a; Smylie, 2001b; Smylie, 2005). Inuit Tapiriit Kanatami (2004) reports that life expectancy among Inuit is significantly lower and rates of suicide for Inuit are higher than those of the general Canadian population. The health of Inuit infants is also grave, with higher rates of infant mortality, respiratory diseases, meningitis tuberculosis, and other infections (Jenkins et al., 2003).

Researchers and practitioners have developed an understanding of health care delivery to Inuit in rural areas (Archibald & Grey, 2000; Thouez et al., 1990). Less is known about the 25% of Inuit who are living in urban areas and potentially are able to access local health care services. Urbanization may mean that the health care needs of Inuit are changing (Bjerregaard, 2005; Christie & Halpern, 1990). Regrettably, there is little evidence that changes have taken place in health organizations to better serve the

³ This study is published. Full reference is McShane, K. E., Smylie, J. K., Hastings, P. D., & Martin, C. M., & Tungasuvvingat Inuit (2006). Guiding health promotion efforts with urban Inuit: A community-specific perspective of health information sources and dissemination strategies. *Canadian Journal of Public Health* 97, 296-299.

changing population of Inuit as there is a paucity of urban Inuit health initiatives among national stakeholders in Inuit health (Young, 2003).

If researchers and clinicians are to provide effective and appropriate health information and services for urban Inuit, a rudimentary understanding of their health information sources and strategies is a prerequisite. This understanding can be gained through a culture- and community-specific assessment of health care processes (Jacobson, Butterill, & Goering, 2003). It is through community collaboration that a solid understanding of health information processes for urban Inuit will be achieved, to subsequently guide health promotion efforts. The current study examines health information sources and dissemination strategies within an urban Inuit community. The ultimate objective of this study is to contribute to the development of a community-specific perspective on health information sources and dissemination strategies.

Method

Participating community. Tungasuvvingat Inuit is an Inuit run community-based counselling and resource centre which aims to empower and enhance the lives of Inuit residing in Ontario. It has been operating in Ottawa since 1987 and offers a variety of community-based counseling and resources, including the Tungasuvvingat Inuit Family Resource Centre (IFRC). The IFRC, where the study was based, houses a pre and post natal program as well as the Child and Family programs (community action program for children) and receives funding from Health Canada. The Ottawa-Hull region is home to the third largest urban Inuit population in Canada with a reported population of 450 Inuit (Statistics Canada, 2001a). Tungasuvvingat Inuit reports that the number of Inuit in Ottawa is actually closer to 1000 persons, which would make it the largest urban

community in Canada. Ottawa also serves as the tertiary health referral centre for Iqaluit and surrounding areas in the Inuit territory of Nunavut.

Community members who participated in the study included a purposive sample of health directors, front line health workers, traditional knowledge experts, elders, youth, and parents who were recruited by community research team members. Twenty community members participated in the first focus group and twenty participated in the second focus group. Through consultation with the community research team, the composition of the focus groups was constructed to reflect a profile of the community. The sample included individuals of varying ages (18 years to over 65 years) and individuals who lived in Ottawa for 6 months or more. The group was largely comprised of females, which is generally reflective of the composition of the Inuit community in Ottawa. Five health information stakeholders (health service providers and Elders) from the community took part in individual key informant interviews.

Procedure. The approach drew on current successful models and recommendations for community-based participatory Indigenous health research (Fletcher, 2003; Green et al., 1995; Macaulay et al., 1998; Royal Commission on Aboriginal Peoples, 1993). Tungasuvvingat Inuit was approached by the principal investigator (JKS) to form a research partnership for the project. With the community representative, a draft community research agreement was prepared explicitly addressing: the project's governance; community expectations and benefits; ownership, control, access, and possession of information; and dissemination of project results. The community's governing body ratified the agreement. The community representative identified community research team members, who subsequently assisted with

recruitment, data collection, data analysis, synthesis, and approval of the study results. The community research team comprised three staff from the Tungasuvvingat Inuit Family Resource Centre. This study was approved by the Health Sciences and Science Research Ethics Board at the University of Ottawa.

Data collection consisted of two parts: (1) initial focus group for gathering of health information and (2) five key informant interviews. A second focus group was for corroboration of results. The following questions were presented to participants for discussion during the first focus group and key informant interviews:

1. If you wanted information on a physical, mental, emotional, or spiritual health issue, where or to whom would you go in this community?
2. How would you decide if the health information that you received was good or not?
3. What kinds of health information have you used in your day-to-day life and work over the past week?
4. If you wanted to spread a health message in this community how would you do it?

The first focus group and interviews were all recorded and transcribed for coding purposes. A qualitative descriptive case study design was used, with the community as the unit of analysis (Stake, 1995; Yin, 1984). Data analysis used a mixed iterative editorial and immersion/crystallization organizational approach (Crabtree & Miller, 1992). Initially, the coding was completed by two trained academic researchers who listed the most poignant themes of the community's health information processes. The community research team also identified themes and a research team meeting was held to

discuss and adapt themes, in order to synthesize them. Following this, the two academic researchers took these preliminary themes and classification systems and conducted a more detailed analysis of the transcripts. Afterwards, a second focus group was held to present the findings for community-based corroboration and one minor change was made in response to comments by participants. Lastly, two members of the academic research team (KEM and CMM) reviewed the transcripts of the initial focus group and 5 key informant interviews and coded the presence of themes, health information sources, and dissemination strategies. Inter-rater agreement was 74%. Disagreements were discussed and evaluated for inclusion in the analysis.

Results

A review of the transcripts revealed 5 themes related to health information processes.

“Inuit way of life is seeing or speaking”. Face-to-face interactions are important for Inuit; they believe that it is necessary to see someone in order to understand that person’s health problems.

We Inuit know by seeing them. When a young woman says that they are ready to get a baby or into labour, they [Elders] say “Not yet” ... They can predict if she’s going to deliver now or later.

Health information is shared through stories. Female Elders provide key advice to their daughters, granddaughters, and other females in the community. Over time, women pass this knowledge on to their daughters who would eventually assume the role of Elders. In contrast, written material about a person’s illness is not very useful for Elders unless it is translated into syllabics. In general, Inuit are disinclined to use written

material; stating “*Papers are not really our thing*”. However, a few participants commented that for a large urban environment, using written communication had some advantages.

Role of Elders in decision-making. Elders are at the foundation of Inuit oral traditions. Individuals access Elders to confirm health information received from other sources. Elders’ advice is commonly sought because of their experience.

When I was pregnant with my son, my first pregnancy, I was having lots of complications and I would, of course, go see my doctors and they would tell me that I don’t have enough iron in me, that’s why I am having this problem. So I would always go to my Elders first before I would go to the Health Centre and they would always find, they would always be right.

Medical and health care knowledge passes through families orally and Elders decide the appropriate context in which to share information. Despite significant geographic barriers between Inuit in Ottawa and Elders in the north, individuals in Ottawa commonly call Elders in the north to get information and advice. Individuals also reported that there appears to be increased evaluation of health care information received from both Elders and non-Inuit sources, especially by Inuit youth.

Community cohesion. All Inuit, regardless of geographic community of origin or immediate family relations, are seen as belonging to the larger Inuit community. This close community connection allows messages to travel quickly within the community. Also, a sense of community is preserved over geographic barriers as reflected in the preserved role of Elders as knowledge holders.

As Inuit, whether you are in the same community or a different community from

up north, you are in Ottawa, you are down here and if you see someone who is needy you help them, no matter if you are related or not.

Inuit and non-Inuit distinction. There is a sense of distinction between the Inuit community and the non-Inuit world. Inuit-specific services have the most cultural relevance, whereas services that are shared with First Nations may be perceived as non-Inuit and less relevant. Knowledge or advice from Inuit, either family or community members, is most well-received.

Cultural interpreters. Inuit report being more receptive to information delivered from other Inuit. However, few linguistic and cultural interpreters are available to the Ottawa Inuit community. This is particularly significant because Inuktitut-speaking Elders cannot transmit their knowledge to non-Inuktitut speaking health professionals and community members without interpretation.

Sources of health information and dissemination strategies. Health information sources are presented in Table 1 and dissemination strategies are presented in Table 2. Sources of health information are categorized according to an environmental conceptual framework (Bronfenbrenner, 1993; Bronfenbrenner, 1989; Bronfenbrenner, 1979; Institute of Population and Public Health, 2005). The core sources of health information are family members and sources from within the Inuit community. The next set of sources is from the larger Aboriginal community and other community members. The final set of sources is from medical community (non-Aboriginal) and general societal sources.

Dissemination strategies for health information centered on direct communication, through one-on-one interactions or in groups. Larger scale dissemination

Table 1.

Sources of Health Information

Conceptual Classification	Source	Impact
Family	Family and extended family	5/6
Community: Inuit Community	Community Elders	5/6
	Local community health centre/family resource centre	4/6
	Community newsletters	2/6
	Conferences, Workshops	2/6
Community: Larger Aboriginal Community	Urban Aboriginal health access centre	3/6
	Community radio	3/6
	Aboriginal organizations	3/6
Community: General	Friends and informal community networks	6/6
	People with past/current experiences of illness	5/6

Table 1, Continued

Sources of Health Information

Conceptual Classification	Source	Impact
<hr/>		
Society: Medical Systems		
(non-Aboriginal)		
	Family doctors	5/6
	Medical centres and hospitals	5/6
Society: Recent Medical		
Advances		
	Email/mail from other organizations, including	3/6
	Health Canada	
	Tele-Health	1/6
Society: General Information		
	Pamphlets, posters, bulletin boards	5/6
	Magazines/books/clearinghouses	3/6
	Internet	2/6

Note. Impact represents proportion of transcripts (1 focus group and 5 key informants) within which this information appeared.

Table 2.

Dissemination Strategies

Conceptual Classification	Strategy	Impact
Direct/Face-to-face		
	Word of mouth	6/6
	Storytelling by Elders	5/6
	Outreach workers	2/6
	Cultural Interpreters	6/6
Discussion		
	Community meals/events	4/6
	Workshops/program presentations	3/6
Seeing/Reading/Hearing		
	Local Radio	5/6
	Pictures/Posters	4/6
	Television/Videos	4/6
	Community Newsletter/Newspaper	4/6
Education		
	Local Aboriginal community organizations	6/6
	Schools	2/6

Note. Impact represents proportion of transcripts (1 focus group and 5 key informants) within which this information appeared. Each source of information (each of the 5 key informant interviews and 1 focus group) was given an equal weighting.

strategies would involve written, audio, or video materials. Finally, education-based strategies were seen as originating largely from Aboriginal organizations, and to a lesser extent schools.

Discussion

Previous research has examined the health care needs of Inuit in rural settings (Thouez et al., 1990) and of Inuit traveling to urban areas for health care (Hanrahan, 2002), but not the health information processes within urban Inuit communities. The current study identified relevant themes and processes within the urban Inuit community in Ottawa. The major sources of health information are from within the Inuit community, principally through Elders, family, friends, staff of the Tungasuvvingat Inuit Family Resource Centre, and family doctors. Additional sources of health information include Aboriginal and non-Aboriginal medical centres. Strategies for dissemination included direct, one-on-one communication. This was seen as particularly effective given the cohesive community structure. The preferences for family and community information sources and direct communication dissemination strategies reflect the prevalent themes of health and well-being originating within, and being perpetuated by, the Inuit community itself.

This community-specific perspective of health information sources and dissemination strategies shows substantial differences from current mainstream models of health promotion and knowledge translation (Canadian Institutes of Health Research, 2002; Smylie et al., 2004b). Compared to the model of *knowledge translation* put forth by the Canadian Institutes of Health Research, the results suggest a need for a direct link between the knowledge users (i.e., community members) and the knowledge products

(i.e., publications). Typical knowledge products (i.e., pamphlets) may need to be replaced by information sources linked to Inuit oral, direct communication traditions (i.e., audiovisual recording). Furthermore, the knowledge users would need to be directly involved in the preparation and presentation of the knowledge. In light of the significant role Elders play as sources of health information, and as disseminators of the information, a considerable part of this process will involve working with already existing community structures. Health promotion efforts will need to acknowledge the distinct health information processes of this community, and should strive to integrate existing health information sources and dissemination strategies with those of the community.

Existing health promotion programs for Inuit and Aboriginal peoples

Researchers in the field of Aboriginal health have widely acknowledged the necessity of involving Aboriginal peoples in the creation, production, and distribution of knowledge (Battiste & Youngblood Henderson, 2000; Castellano, 2000). This is considered particularly crucial given the differences between Aboriginal knowledge systems and Western and biomedical knowledge systems (Smylie et al., 2004b). McShane, Smylie, Hastings, Martin, and Tungasuvvingat Inuit (2006) found Inuit-specific ways in which health knowledge is gathered and disseminated. The community's health information sources and dissemination strategies were distinct from and at times in tension with Western biomedical methods. Thus, as some Indigenous researchers suggest, it is possible that existing materials and resources, usually made by the provincial and federal governments, are not effective because their messages and delivery methods are inconsistent with Indigenous local mechanisms for sharing health knowledge (Smylie et al., 2004a, 2004b).

In order to develop health promotion materials that conform to the health information processes of urban Inuit, it is first necessary to review existing health promotion programs. Particular attention will be paid to the characteristics of such programs and how congruent they are with documented preferences from McShane et al. (2006). Afterwards, it will be possible to delineate the specific areas of incongruency and examine ways in which to create more appropriate health promotion materials for urban Inuit.

Scientific articles and research reports published by various Inuit organizations do not contain any systematic evaluation of health promotion materials or program. This is

not to say that such programs do not exist, but rather they are either not formally evaluated or such evaluations are not formally documented. Current health promotion programs for Inuit have focused on injury prevention, fetal alcohol spectrum disorder, tobacco use reduction, HIV/AIDS and sexually transmitted infections, heart disease, diabetes, mental health, suicide, and abuse prevention (Government of Nunavut, 2006a; Pauktuutit, 2006). Programs often involve multiple components; including school kits, community resource kits, posters, and radio and television broadcasts (Carry & Labranche, 2004). Despite these programs, there is a nearly universal finding that health workers and community members report insufficient health promotion activities and resources (Archibald & Grey, 2000; Kinnon, 2002; Young, 2003).

There is some reason to suggest that even the few health promotion programs that are available in the north are not wholly effective. In a recent review of the treatment of otitis media in Northern communities in Canada, Bowd (2005) noted that two broad value differences have impacted the success of treatment and management programs. First, he noted that public health campaigns focus on the future-oriented consequences of the disease, rather than the immediate consequences. This is considered by some academics as incongruent with Aboriginal peoples' worldview, which is more likely to be present-oriented, than future oriented. Numerous studies attest to the present-oriented worldview of Inuit and Aboriginal peoples (Banks, 2003; Christie & Halpern, 1990; Janca & Bullen, 2003; Poonwassie & Chater, 2001; Steenbeck, 2004). Conversely, Smylie (personal communication, July 6, 2006) has suggested that Aboriginal peoples do hold a future-focus, but that focus is on the future well-being of the family and its members, and not typically on the individual's own future. Thus, the future could apply to an individual's

children and grandchildren. It is definitely the case that current health promotion programming for Inuit focuses on the individual's health practices and future health needs, which is fundamentally inconsistent with Inuit and Aboriginal worldviews.

Bowd also remarked that in Aboriginal communities, harmony is valued over competition. Thus, he suggested that public health campaigns need to begin with community support and resist conceptualizing the campaign as a 'battle' or 'struggle' for health promotion. In all, there is reason to assert that existing mainstream health promotion materials are dissimilar to aspects of Inuit culture and identity.

For Inuit living in urban areas, however, there is the additional potential for incongruity because of differences of community context. At present, all health promotion materials and programs are limited in that they are designed for Inuit in the north only; none are designed for urban Inuit. Although a few descriptive health promotion studies included participants in urban areas in the south, this was limited to gathering information on particular issues (e.g., teenage pregnancy) and not on implementing this knowledge to develop urban-specific health promotion materials for Inuit.

Research on access to health promotion resources by Inuit uncovered specific regional differences between the north and the south. Archibald (2004) reported that participants felt that although access to mainstream resources was easier in the south, these resources were not typically culturally-appropriate and were often not available in Inuktitut. It was also suggested that the south conferred the advantage of anonymity; however, in the south there was less connection to the Elders. In the north, radio announcements and posters were seen as effective; whereas in the south, drop-in centers

were proposed. These results suggest that simply transporting a health promotion program from the north to the south may not result in a program that is equally effective. Also, whereas in the north a multi-component program (e.g., targeting both community and school) may be feasible, such a program is not appropriate in urban areas where Inuit children almost exclusively attend mainstream schools⁴.

Although there are no evaluated health promotion resources for urban Inuit, a few investigations have been conducted with First Nations and other Indigenous peoples who live on reserves in close proximity to urban areas. These research examinations may be able to provide pertinent information about the necessary adaptation of health promotion materials for use with urban Indigenous peoples. One of the most commonly cited examples of health promotion with Indigenous communities is the Kahnawake Schools Diabetes Prevention Project which operates in a First Nations community in the Montreal area (KSDPP; Potvin, Cargo, McComber, Delormier, & Macaulay, 2003). Using participatory action research, the project aims to reduce the incidence of Type 2 diabetes by implementing intervention activities for schools, families and the community which promoted healthy eating, physical activity and positive attitudes about health. This was feasible as the programs were implemented at schools and facilities located on the reserve. They found that successful health messages were those rooted in cultural traditions and adapted to meet the learning styles of Mohawk children.

In another First Nations community near Montreal, Banks (2003) reported on the implementation of a community-based breastfeeding promotion project. The program involved the training of a breastfeeding role model, development of a mothers' support

⁴ It should be noted that in Ottawa there is an Inuit Headstart School; however, it is the only one in southern Canada.

group and talking circle, and media campaigns to share breastfeeding knowledge in the community. The rates of initial and sustained (at 4 months) breastfeeding increased over the five years the program operated (from 32% to 75% and from 19% to 42%, respectively). Banks noted that two keys to the success of the program were: (1) respect for the wisdom of peers and extended family members and (2) recognition of the community's uniqueness and distinctive learning styles. Together these research studies suggest that messages which respect and utilize the community's knowledge and traditions are key characteristics of successful health promotion messages.

Most other studies evaluating the effectiveness of health promotion materials for Indigenous peoples have examined programs at a state or national level. Two studies examined interventions to promote cancer education in Alaska. Cueva, Kuhnley, Lanier, and Dignan (2003) developed a play that explored emotions associated with cancer diagnosis, treatment and pain concerns, loss and grief, as well as healthy lifestyle choices and screening exams. After viewing the play, 66% of viewers reported they had learned something about cancer and 62% identified healthy ways they intended to change their behaviour. Stillwater, Echavarria, and Lanier (1995) piloted a video on cervical cancer education with Alaskan women. The video was designed specifically for Alaskan women, and showcased Alaskan women role models discussing cervical cancer, preventative tests, and healthy lifestyles. After viewing the video, women of all ages showed significant gains in knowledge about cervical cancer and preventative health. Qualitative assessment revealed that viewers liked that the video was culturally-sensitive and that it used Alaskan Native women role models.

Another study examined the efficacy of television programs to promote better nutrition for women, infants, and children in a Native Alaskan community. Smith, George, and Easton (2001) developed short television programs about nutrition, containing cultural content including local history and tradition presented in the native language. Overall, they found significant increases in knowledge and the community expressed interest and acceptance of the program. The researchers concluded that the visual and oral presentation of the nutritional information made the messages more culturally acceptable. Together, these three Alaskan studies found that audio-visual health promotion tools, using stories with cultural role models and culture-specific content were effective in promoting health behaviour.

In a review of health promotion interventions for breast health for American Indian/Alaska Native women, Burhansstipanov, Krebs, Grass, Wanliss, and Saslow (2005) found that breast health outreach, education and screening programs were most effective when they were community-driven and culturally-relevant to specific tribes. Educational messages were most effective when: (i) they were accompanied by visual material (e.g., art or photographs); (ii) the focus was on health and not disease (e.g., 'breast health' instead of 'breast cancer'); (iii) storytelling was used; (iv) the messenger was a community member; and (v) face-to-face communication was used. The authors point out that messages that emphasized the benefits to the family and the community, rather than personal benefit alone, was most effective. These results suggest that the traditional mainstream approaches to health promotion materials may be limited in their efficacy, as they largely focus on personal benefit. In addition, the preferences for types

of materials and methods of communication are consistent with the previously reviewed research about health promotion programs in Alaska.

This small collection of health promotion studies is extremely helpful for identifying successful characteristics of programs and forming hypotheses about the necessary changes that will need to be made for programs for urban Inuit. From the current review of research, specific suggestions can be made regarding the process, medium, source, and content of health promotion resources for urban Inuit. (1) *Process*: To be most effective, materials need to be developed through participatory action research. This will ensure community involvement at all stages of development and will foster greater appropriateness of health promotion materials. (2) *Medium*: A resounding preference for oral-visual information, as well as face-to-face communication was observed across numerous studies, including Study 1. In addition, using existing community structures (e.g., drop-in centres, family resource centres) could be another way to disseminate health promotion resources. (3) *Source*: Respect for Elders was a consistent finding noted in McShane et al. (2006). It was clear that community members, notably Elders, play a crucial and effective role in the dissemination of health information. In addition, given that urban Inuit community members noted reduced connection to Elders (McShane et al.), involving them as spokespersons for health promotion programs will directly address current challenges with the existing model of health information sharing. (4) *Content*: Respect for and utilization of the community's traditional knowledge are key to creating culturally-anchored, community-specific health promotion resources. As well, messages that are available in Inuktitut would also provide effective content. A successful health promotion resource would involve changes in those

aspects. The following study examines the piloting of such a resource with the Inuit community in Ottawa.

Study 2

Evaluation of a CD-Rom as a community-specific health promotion tool for urban Inuit

Introduction

The health of Inuit infants and mothers continues to be a grave concern in Canada. Infant mortality rates are three times higher for Inuit in Nunavut than for the general Canadian population (First Nations and Inuit Health Branch, 2003). Rates of at-risk pregnancies are also elevated for Inuit, compared to the general Canadian population; including elevated rates of teenage pregnancy, prematurity, low birth weight, and maternal smoking during pregnancy (Archibald & Grey, 2000; Health Council of Canada, 2005; Jenkins et al., 2003; Nunavut: Department of Health and Social Services, 2002). Inuit infants and children experience higher rates of respiratory diseases, upper respiratory tract infections, otitis media, meningitis, tuberculosis, and other infections compared to Canadian children (Health Council of Canada, 2005; Pauktuutit, 2002). Together these indicators show that Inuit mothers, infants, and children experience significant disparities in health compared to the Canadian population.

Despite these significant health disparities, the Inuit population has a number of strengths, including a strong and resilient culture and Inuktitut language (Ajunniginiq Centre, 2006). Inuit Elders also possess much knowledge of traditional medicines and techniques, used to treat a variety of physical and psychological health problems (Bennett & Rowley, 2004; Grey, 1996). The Inuit have strong kinship networks (Penney, 2004), which has been linked to the flow of health information within an urban Inuit community (McShane et al., 2006). In all, these strengths of the population must be recognized and considered when examining health interventions to address the disparities.

Researchers in the field of Inuit health have called for a significant health renewal process to help overcome the health disparities (Duncan, 2006). Health Canada's ten-year plan to strengthen the health care of Canadians has health renewal as its focus (Health Canada, 2006). Health Canada has outlined three objectives of the health care renewal of Inuit: (i) improve the health outcomes for Inuit; (ii) improve access to health care services; and (iii) increase Inuit control of health programs (Duncan, 2006). One element which is considered to be necessary to achieve these objectives is the development of more effective health promotion programs (Duncan, 2006).

Public health campaigns, including health promotion materials, offer the possibility to reach large numbers of individuals. Given the strong kinship ties in Inuit communities (McShane et al., 2006; Penney, 2004), health promotion programs represent a viable approach to improving the health of Inuit. To date, there are few health promotion tools for Inuit (Archibald & Grey, 2000; Kinnon, 2002), and no published reports on evaluations of health promotion materials for Inuit. In addition, there is a specific lack of health promotion materials for Inuit who live in urban regions in the south. Given the increasing numbers of Inuit living in urban regions (Roy-Sole, 2005) and the documented differences between the north and the south in accessibility of and needs for health promotion materials (Archibald, 2004), it is vital that health promotion materials for urban Inuit be developed and evaluated. Furthermore, the development of such materials should emphasize self-determination, which has long been recognized as necessary for success by Aboriginal peoples (Royal Commission on Aboriginal Peoples, 1993) and more recently by the federal government (Health Canada, 2001).

The current study evaluated a new health promotion resource for urban Inuit, designed to maximize existing health knowledge sources and dissemination strategies (McShane et al., 2006) and adhere to ethical guidelines for respectfully engaging in research with Aboriginal communities (Fletcher, 2003; Royal Commission on Aboriginal Peoples, 1993). The tool, a CD-Rom entitled *Planning for a healthy family*, was developed specifically for the Inuit community in Ottawa based on the articulated preferences for medium, source, and content (McShane et al.). The CD-Rom focused on the health of mothers and infants, considered a priority given the sizeable disparities in health status.

Process: The use of participatory action research. Although health promotion materials were once administered in a top-down fashion, the current national and international trend highlights the values of self-determination, respect, caring, and equality (Buchanan, 2000). It is recognized that past health promotion efforts often left people feeling disempowered as the assumption was that people were capable only of using information and not producing information (Freire, 1970; 1973). The Ottawa Charter for Health Promotion written in 1986 also highlights the importance of community empowerment (World Health Organization, 1986). Currently, health promotion is conceptualized in terms of both personal and community empowerment (Steenbeck, 2004). The Romanow report reflects to a certain extent the shift in conceptualization of health promotion. In particular, it was recommended that Aboriginal people be involved in how health care services were designed and delivered (Romanow, 2002). Participatory action research (PAR) could serve as an avenue to ensure a close connection between Aboriginal people and the construction of health promotion materials, and thereby

empowering Aboriginal peoples and communities. Thus, PAR represents a necessary element of any successful health promotion program for Inuit and other Indigenous groups.

Medium: Matching oral-visual learning style of Inuit. Smylie and colleagues (2006) examined health promotion material at the Tungasuvvingat Inuit Family Resource Centre in Ottawa and found only one Inuit-specific tool, which was a pamphlet in Inuktitut and English. However, this tool was not made in collaboration with communities. Results from McShane et al. (2006) showed that the preferred medium for learning about health was oral, and more specifically through stories. Thus, at present, available health promotion materials developed specifically for Inuit are not consistent with their learning styles and preferences.

Other research has documented Inuit learning styles, although this research is limited to Inuit in the north. In a classroom setting where skills are being taught, traditional Inuit learning involves silent observation and listening to other more skilled individuals (Crago, 1992). Outside of skill-based learning, Inuit teachers promote peer discussion and interaction and student contributions to instruction (Crago, 1992; Crago, Annahatak, & Ninguiruvik, 1993; Eriks-Brophy & Crago, 1993). Adults learning traditional basket-making in Nunavut learned through observation, oral instruction, and dialogue with Elders (Cowan, 2005). *Reciprocity* was at the core of this teaching-learning environment, and the learning was communal where the educator was a co-learner as well. In sum, Inuit learning styles can be characterized as oral, visual, observation-based, and involving group discussions, and a respect for reciprocity in knowledge exchanges. However, it is unclear exactly what aspects of these styles will be similar to those of

urban Inuit. Interactive CD-Rom technology appears advantageous for use with Inuit because the use of graphics and recorded messages is congruent with Inuit culture, which is based on visual learning and oral traditions. Furthermore, given that the CD-Rom is user-driven, it will provide a sense of control for learners (Gustafson, Bosworth, Chewning, & Hawkins, 1987).

Outside of Aboriginal health, the use of CD-Roms for health information dissemination is in its infancy. Only a handful of studies have assessed the effectiveness of providing health information through CD-Roms. For the most part, these CD-Roms have focused on health information following surgery. Yeh, Chen, and Liu (2005) examined the use of a CD-Rom to disseminate health information regarding hip replacement surgery and found that patients who viewed the CD-Rom had greater self-efficacy and functional activity, and shorter hospitalizations. Danino et al. (2005) assessed the use of a CD-Rom that provided information on potential surgical outcomes following breast reduction or abdominoplasty. They found that patients who viewed the CD-Rom had greater surgery-related knowledge and decreased anxiety following surgery. Dragone, Bush, Jones, Bearison, and Kamani (2002) developed a CD-Rom to provide children with leukemia and their parents information about medical procedures and coping strategies. Compared to children who read a book about having leukemia, children exposed to the CD-Rom reported increased feelings of control over their health and greater satisfaction with the intervention. In all, this group of studies suggests that CD-Rom technology can offer an effective tool for health promotion and illness prevention.

To date, no published study has reported on the use of a CD-Rom as a tool for knowledge sharing or health promotion with Inuit. The only study which examined the use of technology for health with Inuit evaluated an online course for training community health care workers in Nunavut (Hamilton et al., 2004). The course provided nutritional information, presented through a series of stories of fictional family members (e.g., pregnant woman, breastfeeding woman, Elders). The participation rate for this oral- and visual-based media was low (40%). The researchers noted that barriers to participation included difficulties with internet access, lack of experience using the internet, lack of ease in a text-based environment, and for many participants, the fact that the course was being delivered in a language other than their mother tongue. Much of these results are relevant to the current project and to the implementation of technology-based resources. In particular, it is necessary to ensure that assistance is provided in utilizing the technology and that messages are also in Inuktitut.

In addition, it is clear that a notable component of Inuit learning styles involves face-to-face interactions. Although a CD-Rom affords superb opportunities for oral and visual communication, it lacks an ability to capture face-to-face interactions. A community facilitator set-up and viewed the CD-Rom with each participant. This one-on-one assistance in accessing the health promotion tool was similar to what a *care navigator* does for those individuals receiving health care or treatment (Martin, Banwell, Broom, & Nisa, 1999). A care navigator is responsible for coordinating, educating, facilitating access to health care for community members and patients. In the broader health care field, the care navigator is also involved in liaising and undertaking advocacy, transitioning and integrating patients to supportive and palliative care, supporting

activities of daily living and informing about community volunteer organizations (Martin, et al., 1999). Initially, the role of the care navigator was in response to health care reform which sought to improve access to services and resources for patients with chronic disease and cancer (Cancer Care Nova Scotia, 2002). In the current project, the community facilitator acted as a care navigator and assisted the participants as they used a new health promotion tool. It was anticipated that the use of a community facilitator would respond to the preference for face-to-face communication.

Source: Capitalizing on the pivotal role of Elders. Results from McShane et al. (2006) demonstrated the importance of Elders as sources and disseminators of health information. The significance of Elders in health promotion programs has previously been noted with Inuit communities. Archibald (2004) found that Elders could play an important role in public education about teenage pregnancy. In Aboriginal communities, Elders are involved in the creation and dissemination of culturally-appropriate messages within the community (Stiegelbauer, 1996). They are role models and advisors for health and healing and are involved in story telling, teaching and sharing circles, and ceremonies (Poonwassie & Chater, 2001). In traditional Inuit communities, this process of knowledge sharing is natural and effective. For instance, in the north Elders routinely teach about the land and the traditional way of life (Takano, 2005). However, with increasing numbers of Inuit moving outside of their communities, this process has become difficult. It is recognised that the shift from land-based to settlement-based life has resulted in a breakdown of this traditional mechanism of teaching. It is noteworthy that McShane and colleagues found that urban Inuit were calling “up north” to consult Elders about health information. Thus, being able to bridge the gap between the north and

south would represent a mechanism to aid in the restoration of the traditional knowledge sharing process. Therefore, an Inuk Elder presented the health messages in the CD-Rom.

Content: A focus on Inuit-specific. As suggested above, a CD-Rom would need to present messages in both Inuktitut and English. Such a tool could provide vital resources for urban Inuit, who have previously indicated a shortage of culturally-appropriate Inuktitut resources in Ottawa (Archibald, 2004). Furthermore, in recognition of the importance of Inuit specific health information, it will be necessary to focus specifically on traditional Inuit health knowledge, and rather than traditional Aboriginal knowledge. Although the Romanow report was innovative in its recognition of the role Aboriginal peoples should play in the development of health programs and services, a major criticism was its attempt to tackle Aboriginal issues from a pan-Aboriginal perspective, disregarding the unique and specific factors affecting the health status and outcomes of Inuit, First Nations, and Métis (MacKinnon, 2005). In fact, initial research findings from a comparative study of health information processes of an Inuit, First Nations, and Métis community, found some overlap, but reported principally distinct patterns (Smylie et al., 2005). Thus, it is necessary that health promotion materials be developed for Inuit specifically, and not based on pan-Aboriginal approaches to health promotion. Working with the Inuit community and showcasing an Inuk Elder ensured that the content retained strong ties to traditional knowledge and to the Inuit culture.

Objectives of present study. The goal of the present study was to evaluate the effectiveness of a guided CD-Rom as a health promotion tool for urban Inuit in Ottawa. The CD-Rom that was generated presented two messages about pregnancy and family health. The topics were selected by the Elder and are particularly relevant topics given

the current health disparities of Inuit mothers and infants. In addition, given that the project took place at the Tungasuvvingat Inuit Family Resource Centre, a focus on prenatal care was considered by the community research team members to be relevant to the clients. The use of oral and visual media in the CD-Rom represented a match to Inuit learning styles and documented preferences for health information dissemination. Health messages were presented in Inuktitut, by a respected Inuk Elder, and contained Inuit-specific health information. Together, the medium, source and content were expected to make the CD-Rom an effective health promotion resource. It was hypothesized that after viewing the CD-Rom individuals would: (1) share the information with others; (2) consider the medium effective; (3) evaluate the source positively; and (4) consider the content helpful.

Method

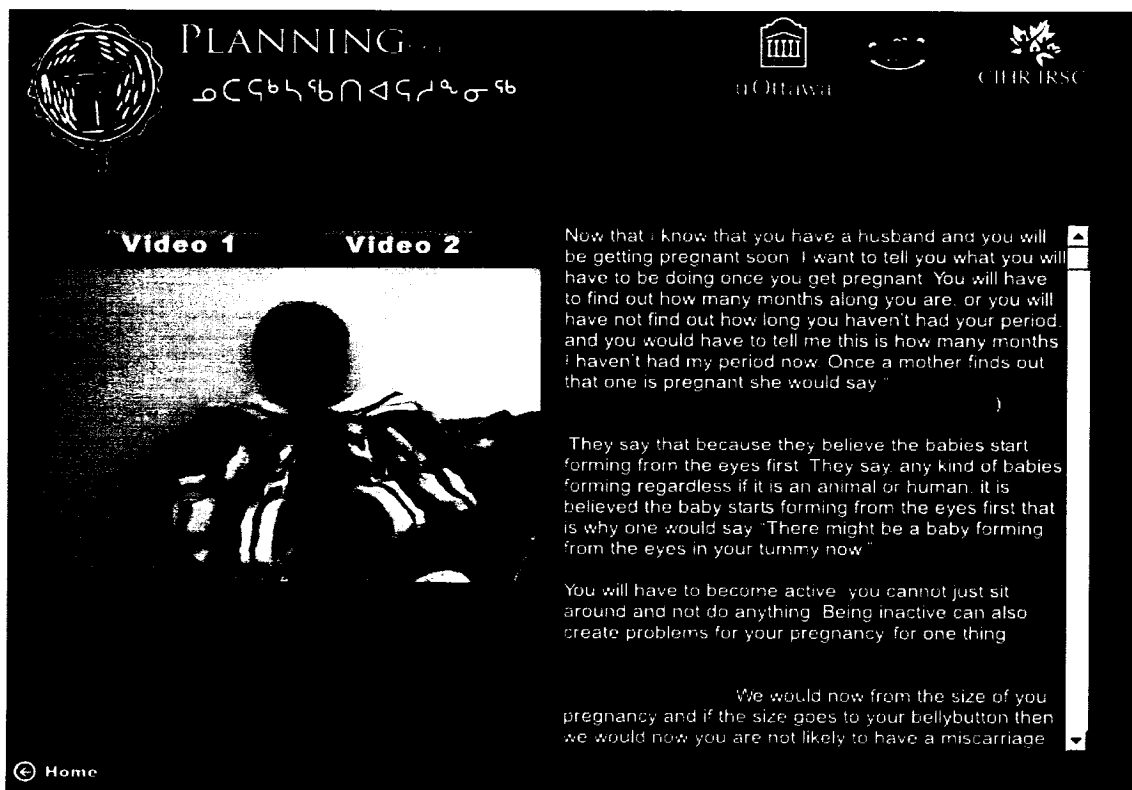
Participants. Individuals were recruited from the Tungasuvvingat Inuit Family Resource Centre, in Ottawa. Potential participants were initially identified by the community research team members. Identified individuals were provided with a description of the study and then were invited to participate if they were interested (all those contacted agreed to participate). Forty adults were recruited to participate in the study ($M=39.20$ years; $SD= 12.32$ years). This sample included 9 males and 31 females. One participant did not complete the initial interview and another participant did not complete the initial questionnaire. Four participants did not complete the post-CD-Rom evaluation. Three were no longer interested in participating in the study, and one returned to live in the north.

Materials. The CD-Rom was developed in consultation with two community Elders (from the north) and the academic and community research team. Video segments were selected from a series of brief teachings an Elder provided on midwifery and prenatal care. The CD-Rom, entitled, *Planning for a Healthy Family*, contained two segments, each with a recorded teaching (and accompanying text), and set of summary slides containing major themes and illustrations (see Figures 4 to 7 for screen shots of the CD-Rom). One message focused on pregnancy and labour, and the other focused on how to support mothers during pregnancy (see Appendices B and C for English text of messages one and two, respectively). The CD-Rom offered users the choice between Inuktitut and English. Seventeen individuals viewed the CD-Rom in both English and Inuktitut, 14 viewed the CD-Rom in English, and nine viewed the CD-Rom in Inuktitut.

Evaluation materials were created using a program evaluation approach, which consisted of breaking down the study's objectives into strategies and indicators that could be quantifiably assessed (see Table 3) (Waa, Holibar, & Spinola, 1998). Based on the performance indicators, questions were developed through consultation with the community research team members. Open-ended questions were direct and succinct (e.g., "Tell me what it will be..." vs. "What do you think it will be..."). In the questionnaire, comparison questions were avoided as they would have required changing the scale anchors, and this was believed by the community research team to create confusion for respondents. For instance, "Do you think information from an Inuk is better than information from a non-Inuk?" was changed to "Was it good that the information came from an Inuk?"

Figure 4.

Screen shot of message 1: Video view (English)



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Video 1 Video 2

Now that I know that you have a husband and you will be getting pregnant soon I want to tell you what you will have to be doing once you get pregnant. You will have to find out how many months along you are, or you will have not find out how long you haven't had your period, and you would have to tell me this is how many months I haven't had my period now. Once a mother finds out that one is pregnant she would say "

They say that because they believe the babies start forming from the eyes first. They say, any kind of babies forming regardless if it is an animal or human, it is believed the baby starts forming from the eyes first that is why one would say "There might be a baby forming from the eyes in your tummy now."

You will have to become active, you cannot just sit around and not do anything. Being inactive can also create problems for your pregnancy for one thing

We would now from the size of you pregnancy and if the size goes to your bellybutton then we would now you are not likely to have a miscarriage

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Figure 5.

Screen shot of message 1: Summary slide view (English)

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WHAT YOU NEED TO KNOW ABOUT PREGNANCY

Video 1 Video 2

- Being active during the pregnancy is important.
- When mothers are aren't active, the placenta might get stuck in the uterus.
- After 3 months of pregnancy, mothers are not likely to have a miscarriage.

Home

Table 3.

Mapping of Strategies and Indicators on Project Objectives

Goals	Objectives	Strategy	Performance Indicators
To develop an effective Inuit knowledge translation approach.	To devise a new way of sharing health information	-Meeting with academic and community research team members -Hiring of community facilitator -Creation of CD-Rom	-team members recognize similarity between elements of CD-Rom and preferences indicated in Study 1.
	To ensure new way of sharing information is relevant to the Inuit community.	-Questionnaires -Interviews	Areas to be assessed: -evaluation is positive -content is appropriate -source is positive -medium of sharing information (CD-Rom)

Table 3. Continued

Mapping of Strategies and indicators on Project Objectives

Goals	Objectives	Strategy	Performance Indicators
To develop an effective Inuit knowledge translation approach.	To assess which factors of the tool and message are most important	-Questionnaires -Focus Groups	Areas to be assessed: -source (Elder, Inuit) -content (Inuktitut, English, topic) -medium (CD-Rom, community facilitator)

In creating the scaled questions, it was first necessary to select an appropriate scaling system. Given the visual nature of the Inuit instruction and learning, five pie charts were used with three anchors (“no”, “maybe”, and “yes”). In addition, no mid point anchors were used to denote ‘2’ and ‘4’. In English there are many scale anchors that could have been used (e.g., “kind of”, “a bit”, “a little”, etc), however in Inuktitut such qualifiers do not exist. As such, the decision was made to use only three anchors.

The questionnaire items assessed four construct areas: (i) evaluation; (ii) medium; (iii) source; and (iv) content. The final questionnaires and interview items were presented to the community research team members for their approval. Two sets of questionnaires and interview items were developed; one to assess expectations (*Pre*) and the second to assess reactions to viewing the CD-Rom (*Post*). The wording for the pre- and post-questions was similar enough to allow for appropriate comparisons to be made, while avoiding exact duplication of questions. The interview items and questionnaire for the *Pre* phase are presented in Appendices D and E, respectively. The interview items and questionnaire for the *Post* phase are presented in Appendices F and G, respectively. A final set of evaluation materials was developed for the focus group, which comprised the third phase of data collection (*Follow-up*). Focus group questions are presented in Appendix H. Content areas for focus group and questionnaire items were first identified by examining the project’s larger goals⁵. All materials were translated into Inuktitut prior to commencing the data collection. In addition, an interpreter was used to translate questions in the focus group.

⁵ As this evaluation was part of a larger project examining Indigenous knowledge and community partnerships, certain items were also included to assess these content areas. However, for the purposes of the current project, they were not analyzed and are therefore not discussed.

Procedure. This study is part of a larger study examining health information processes. Refer to Study 1 for a more detailed description of the development of the partnership with Tungasuvvingat Inuit Family Resource Centre and a description of the participating community. This study was approved by the Health Sciences and Science Research Ethics Board at the University of Ottawa. Data was collected at the Tungasuvvingat Inuit Family Resource Centre, by two community research team members⁶.

Interested individuals were identified by community research team members and were then provided with a description of the study. If they were interested, participants were presented with a consent form in English and were provided with a description of the study and the consent process in Inuktitut (if they so desired). At the first data collection point, participants initially answered a set of interview questions related to another study (see Study 3), and then answered the interview questions regarding their expectations of using the CD-Rom. Afterwards, they completed a questionnaire. Approximately one month later (*Post*), participants viewed the CD-Rom with the assistance of a community facilitator. Afterwards, all participants completed a questionnaire and a subsample of participants ($n=10$) completed a brief interview. A final focus group was conducted two to three months following the viewing of the CD-Rom, where a subsample of the participants ($n=20$) participated in a focus group (*Follow-up*). Each participant was remunerated \$15 per session.

Participants were given a choice of conducting the interview in Inuktitut or English. Similarly, participants were given the choice to: (a) read the questionnaire

⁶ Three participants were interviewed by a research team member (KM) who was not a community member; however community research team members were present to provide any necessary translations.

themselves; (b) have the questionnaire read to them in English; or (c) have the questionnaire read in Inuktitut by the community facilitator. This methodological flexibility was deemed necessary as the goals of the study were to create an environment that would promote participants' comfort and maximize the information gathered. Previous research with Alaska Natives found that such flexibility increased trust, ensured participants a sense of control, and communicated understanding and respect for the participants in the study (Mohatt et al., 2004). Twenty-seven individuals completed the interview and questionnaire in Inuktitut and 13 completed them in English.

The interviews were all recorded, transcribed and translated for coding purposes. Data analysis used a mixed iterative editorial and immersion/crystallization organizational approach (Crabtree & Miller, 1992). Initially, the coding was completed by two trained academic researchers who listed the most poignant themes from the expectations of using the CD-Rom. A meeting was held between the two coders and the community research team to discuss and adapt themes. Following this, the two academic researchers took these preliminary themes and classification systems and conducted a more detailed analysis of the transcripts and finalized the coding scheme (see Appendix I for expectations coding scheme). The principal coder coded all transcripts and the reliability coder coded 20 of the expectations transcripts. Inter-rater agreement was calculated using intra-class correlations and was found to range from $r=.62$ to $.89$. Disagreements were discussed and evaluated for inclusion in the analysis.

Results

Preliminary analyses. In order to assess any differences in ratings as a result of language, mixed multivariate analysis of variance (MANOVAs) were performed, with

time and outcome category as within subjects variables and language as a between subjects variable. Four MANOVAs were performed, one for each outcome category: (i) Evaluation (items 2, 3, and 4); (ii) Medium (items 10, 11, and 12); (iii) Content (items 5, 6, and 7); and (iv) Source (items 8 and 9). The MANOVA for medium revealed a significant main effect for language, based on Wilks' criteria, $F(3, 29)=7.71, p<.01$, partial $\eta^2 = .44$, but no language by time interaction, $F(3, 29)=1.37, ns$, partial $\eta^2 = .12$. Inspection of the specific dependent variables showed a significant language effect for item 11 (CD-Rom like talking to someone), $F(1, 31)=27.64, p<.01$, partial $\eta^2 = .30$, and for item 12 (CD-Rom like reading a brochure), $F(1, 31)=34.91, p<.001$, partial $\eta^2 = .38$. For both items 11 and 12, ratings completed by Inuktitut-speakers ($M_s=3.90$ and 4.40 , $SD_s=1.37$ and 0.91 , respectively) were higher than ratings completed by English-speakers ($M_s=2.93$ and 3.12 , $SD_s=1.08$ and 1.20 , respectively). Therefore, Inuktitut-speakers expected and found their interactions with the CD-Rom to be higher in similarity to both talking to someone and reading a brochure, compared to English-speakers. No other MANOVA was significant. As the language by time interaction was not significant, it was not necessary to control for language in the quantitative analyses assessing changes in ratings.

Quantitative analyses. Multivariate analyses of variance (MANOVAs) were performed to examine differences between pre and post ratings. A series of within-subjects MANOVAs were performed, with time and outcome category as independent variables. Four MANOVAs were performed, one for each outcome category: (i) Evaluation (items 2, 3, and 4); (ii) Medium (items 10, 11, and 12); (iii) Content (items 5, 6, and 7); and (iv) Source (items 8 and 9). Descriptive statistics are presented in Table 4.

Table 4.

Descriptive Statistics of Outcome Measures

Outcome Category	Item	Pre		Post	
		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Evaluation (<i>N</i> =31)					
	2	4.26	1.18	4.84	.64
	3	4.71	.64	4.90	.40
	4	4.90	.30	4.84	.52
Medium (<i>N</i> =33)					
	10	4.61	.79	4.79	.78
	11	3.33	1.49	4.21	1.32
	12	3.85	1.18	3.91	1.68
Source (<i>N</i> =34)					
	8	4.94	.34	5.00	0
	9	4.94	.34	5.00	0
Content (<i>N</i> =31)					
	5	4.42	.89	4.90	.40
	6	4.40	.84	4.61	.96
	7	4.87	.56	4.81	.65

The overall multivariate test for a time effect on the three evaluation dependent variables, based on Wilks' criteria, was significant, $F(3, 28)=4.71, p<.01$, partial $\eta^2 = .34$. Inspection of the specific dependent variables revealed a significant effect for time for item 2 (recommend to someone), $F(1, 30)=5.09, p<.05$, partial $\eta^2 = .15$. Ratings of likelihood to recommend the CD-Rom were higher after having viewed it.

The overall multivariate test for a time effect on the three medium dependent variables, based on Wilks' criteria, was significant, $F(3, 30)=3.84, p<.05$, partial $\eta^2 = .28$. Inspection of the specific dependent variables revealed a significant effect for time for item 11 (CD-Rom similar to talking to someone), $F(1, 32)=11.73, p<.01$, partial $\eta^2 = .27$. Ratings of similarity to talking to someone were higher after having viewed it.

The overall multivariate test for a time effect on the three content dependent variables, based on Wilks' criteria, was marginally significant, $F(3, 28)=2.67, p<.10$, partial $\eta^2 = .22$. Inspection of the specific dependent variables revealed a significant effect for time for item 5 (message clarity), $F(1, 30)=7.85, p<.01$, partial $\eta^2 = .21$. Ratings of how much sense the message made were higher after having viewed it.

The overall multivariate test for a time effect on the two source dependent variables, based on Wilks' criteria, was not significant, $F(1, 33)=1.00, p>.10$, partial $\eta^2 = .03$.

Qualitative findings. To supplement and clarify the quantitative results, the interviews conducted prior to viewing the CD-Rom were coded for themes. Three main themes emerged: interest ($M= 1.76, SD=1.24$); uncertainty ($M= .58, SD=.64$); and conditional interest ($M= .39, SD=.60$). Individuals expressed an *interest* in the CD-Rom, including the technological aspects of the tool, the cultural content (language and Elder), as well as the information contained in the tool. They also spoke about their intent to use

the information and the CD-Rom, and some requested a copy of the CD-Rom at the end of the study. Sample responses include: “I’m sure the CD-Rom that you are putting together is put together very well, I’m really looking forward to it”, “I think it will be neat and I can’t wait to try it”, and “I know I’m going to want one, I know it’s going to help a lot of people”.

Individuals expressed a general *uncertainty* about the CD-Rom. Some expressed concern specifically about technology (e.g., ability to use computer, navigate tool). Others mentioned concern about the content, for instance expressing concern about the ability to understand the message and language. Examples included: “I’ve never used a CD-Rom before” and “Depends what it’s all about”. Some individuals expressed an interest in the CD-Rom and its information if a certain *condition* was met. These criteria included: easy of technology, clarity of content, and cultural-appropriateness of message. When participants were asked if they would be able to use the information, responses included “Very much, if they are in Inuktitut and if I understand it in English”, “If I’m doing it with someone” and “Sure if there is any kind of parenting stuff and children, <I> find those things educational”.

Because there were only ten post-interviews completed, no formal thematic coding was undertaken. Instead, the interviews were examined for: (i) support of the quantitative findings; (ii) clarification of the qualitative themes from the pre-viewing; and (iii) identification of new issues that were not assessed. Two quotes support the increase in ratings of likelihood to recommend the CD-Rom.

Yah I would, if I had a daughter, or a daughter-in-law, I would definitely use it.

Because it is hard to really talk about it, about pregnancy when you don’t

understand a whole lot about it. So it is going to be, yah I would definitely, to my daughters, to my friends, to who ever.

For the teenagers it will be very helpful, especially for the teenagers who don't know much about pregnancy.

The quantitative analyses also showed there was also a significant increase in ratings of how similar the CD-Rom was to talking to someone. When asked what the person liked most about the CD-Rom, two participants commented:

The person is speaking and giving good information and giving good instruction in terms of when it comes to a mentor thing when you are pregnant.

I remember when my grandparents used to tell stories to them, and that reminded me of them. I like it because it's memory of my parents.

There was also an increase in ratings of how much the message made sense. One person said "The information that they get is really understandable". Another person said:

All of it you should be listening to, you know, when it comes to a pregnant mother should not be under stress and stuff like that, you know, the Elders know that, that's probably a huge problem.

The quantitative ratings showed that the source, being from an Inuk and from an Elder, were extremely high at both pre and post viewing. Clearly, these two features were extremely important to individuals. In the post-interviews, when asked what they liked the most, two individuals commented:

It was just nice to see that it was an Inuit and that it could help some people.

The Elder, her, I think that is beautiful, and the words that she mentioned is all true, traditional information. It's beautiful, especially her amauti.

When the post-interviews were examined for clarification of initial qualitative themes, numerous positive comments were made about the CD-Rom. When asked how the CD-Rom was different from what was expected, two individuals said:

It's Inuit, which is different, which is better, it's good.

It is coming from an Elder, an Inuit Elder, it's, I never knew that a baby develops from their eyes first and it was very interesting and a lot of information was very cool too.

Prior to viewing the CD-Rom, concern and uncertainty were expressed about the technology, content, and clarity. It appears that the concern about the user-friendliness of the technology was eased, as overall most people had very favourable reports about the CD-Rom: "It was easy, very easy", "I liked how easy it was to navigate", and "Very easy, very simple, that's about it". One person commented directly about the layout of the CD-Rom:

Umm, it's pretty good the way the video played, and the writing, and you can click onto, if you are not sure, or if you want to learn more.

New topics were also present in the post interviews. Individuals commented about the length of the CD-Rom, stating "It was too short, I want more information because it is so important". One comment made reference to the wholistic nature of health, stating that

the CD-Rom was “Helpful with the mental part, we need that too”. One comment suggested that the information was perhaps dated:

Umm, it was more about how things were, then how things are. She was talking more about how things were when she was pregnant, then how things have changed.

A couple of comments pertained to the text and written content. Some comments were positive, other indicated areas for improvement.

I liked how it showed the Elder speaking and also had the words written so I can hear it and read it at the same time.

It needs fixing a bit, the syllabics, when that is done, it will be a little more better.

Follow-up qualitative findings. A focus group was held three months after the last viewing of the CD-Rom to further document community members’ evaluation of the CD-Rom. The timing of the focus group allowed for a short-term follow-up, which provided community members time to reflect on the CD-Rom. When community members were asked which feature they preferred the most about the CD-Rom, they were divided between ‘All’ and ‘the Elder’. One person described the effect of the Elder’s voice.

I found <the Elder> to be, her voice is very soothing she is very low key, it’s very easy to listen to her, and her, she has a very benign, not a preachy kind of demeanor, she’s passing on information, and that, there just something very easy to listen.

Some people commented about liking the traditional information and the fact that the CD-Rom was set up with two focused messages. The wholistic nature of the messages was again mentioned.

She like<s> the idea of talking about pregnancy from a wholistic point of view with the help of the mother and the help of the father and that is something that we need talk more <about> as a family value.

Others made comments about the visual information. For instance, two participants stated:

The visual <is> really good for him because of the traditional Inuit parka that she had on.

The visuals good too because even when you have it in English you can still read her body language.

When asked what they would change about the CD-Rom, community members stated that the message was too short, similar to the comments directly after viewing the CD-Rom. Individuals were divided about whether there should be a few long messages, or whether there should be many short messages. One person commented about the English translation: “As an urban Inuit I thought the English translation was a bit repetitive, so maybe have it ah, more edited a bit on the translation”. There was a request for additional topics, akin to a series that the Elder could talk about.

What she would be very interested in, expanding on, is on talking about delivery, actually, child birth, pregnancy, child birth delivery... right up to child rearing, to a toddler, and that would be a lot of information that would be very useful for new parents.

There were also a few comments about enhancing the technology by allowing for a full screen viewing and mouse-over pop-up features for the graphics.

When participants were asked about how the CD-Rom compared to other ways of sharing information, a few individuals commented that “It’s not just something you can just pick up and throw away”. One comment was made that it was not as good as face-to-face, but it was better than paper-based information. There was a discussion around accessibility, given that a computer is needed. However, others pointed out that a computer was available at the Tungasuvvingat Inuit Family Resource Centre.

Discussion

Few health promotion tools have been evaluated for use with Inuit, and none have been developed for urban Inuit specifically. This study evaluated the effectiveness of a guided CD-Rom as a health promotion tool for urban Inuit in Ottawa. The CD-Rom contained two messages about pregnancy and family health, which were selected by the Elder. The topic is pertinent given the current health disparities of Inuit mothers and infants and the fact that the study was completed at the Tungasuvvingat Inuit Family Resource Centre. The tool was designed to match Inuit learning styles and documented preferences for health information dissemination (McShane et al., 2006). It was expected that after viewing the CD-Rom, individuals would: (1) share the information with others; (2) consider the medium effective; (3) evaluate the source positively; and (4) consider the content helpful.

The quantitative analyses largely supported predictions. Despite initial expectations being highly positive, overall increases in evaluation ratings were observed, in particular when assessing the likelihood to recommend the tool to another. This is

particularly significant as it suggests that this tool represents a viable medium for information sharing. It is also very encouraging that even though the CD-Rom focused specifically on pregnancy and prenatal care, a broad range of community members nevertheless would recommend the tool to others. This might be because prenatal teachings are important to all members of the community, regardless of their stage of life. Another explanation for this could be that although the content of the messages was specific, the messages were judged to be family-centered and wholistic. A couple of individuals reported specifically appreciating the ‘mental’ aspects of the prenatal care message and the inclusion of both parents and other family members when discussing pregnancy.

In addition, the messages provided participants the opportunity to gain more knowledge about traditional Inuit health. As one person commented, “I’m half Inuit and I don’t know a lot of our traditional ways so this will give me a good idea of the traditional ways.” Furthermore, given that the Inuk Elder was from the north, this provided community members with an opportunity to learn new Inuktitut words. Given that the Inuktitut language has changed over the years, it is extremely important that traditional Inuktitut words survive (Pauktuutit, 1990). The CD-Rom provided an excellent tool to aid in the retention of both language and culture. The desire to retain culture and language has previously been documented with urban Inuit (McShane et al., 2006), as well as Inuit in the north (National Aboriginal Health Organization, 2003; Takano, 2005). Likewise, numerous research papers comment on the specific role Inuit Elders play in promoting knowledge, language, and culture (Pauktuutit, 1990).

Ratings of similarity between CD-Rom and engaging in a conversation with someone increased from pre to post. This is significant because face-to-face communication has been identified as one of the key methods of sharing health information in the urban Inuit community. Furthermore, community members have previously commented about the difficulty accessing Elders (McShane et al., 2006). If the CD-Rom is similar enough to talking to someone, it could represent a feasible and cost-effective method to link Elders with urban Inuit populations.

The content of the messages was also clear, as ratings on clarity increased from pre to post, despite some initial concerns expressed in the qualitative interviews. This could indicate that participants were unsure of what to expect, perhaps as a result of the technology. Individuals were able to discuss specifically what they had gained from the message, further evidencing the clarity of the message.

It was predicted that the source of the message, the Inuk Elder, would be rated positively. Indeed, results showed that the ratings of the message source were high. However, no changes were detected from pre to post. This is largely because a ceiling effect was observed: Ratings went from $M=4.94$ to 5.00. Nevertheless, it can be concluded that the source was rated positively. The interviews and follow-up focus group further highlighted the importance of the Elder in the success of the CD-Rom. This has similarly been observed by Stillwater and colleagues (1995) in their work on health promotion for cervical cancer with Alaskan women. Overall, these results suggest that health promotion tools for Inuit will be most successful if Elders are involved in the project.

Despite the numerous positive responses to the CD-Rom, there were some comments about how it could be improved. The CD-Rom was selected as the 'health promotion tool' for its strength in visual and oral media. Less emphasis was placed on the written text (both Inuktitut syllabics and English) given the previously documented preference for oral and visual material (McShane et al., 2006) and learning styles of Inuit (Cowan, 2005; Crago, 1992; Crago et al., 1993; Eriks-Brophy & Crago, 1993). However, a few comments were made about the need for improvements on the wording, albeit only minor improvements were recommended. In addition, some comments were made about the repetitive nature of the English translation. In all, these comments suggest that the written material should not be overlooked, as it is an important feature of the CD-Rom and an important source of information. Comments were also made about the length of the messages and it was often suggested that more information be provided, on additional topics. More specifically, participants indicated an interest in information on childrearing from infants to toddlers.

Another set of comments was directly related to the technological aspect of the health promotion tool. Prior to viewing the tool, community members expressed concern and uncertainty about the user-friendliness of the CD-Rom. For the most part, it appears that the CD-Rom was easy to navigate, based on the comments provided at the post-interviews. It is possible that having a community facilitator present during the viewing of the CD-Rom allayed participants' concerns. It is unclear if individuals would have regarded the CD-Rom as easy to use if they had been using a computer on their own, potentially in their home. Also, there remains the issue of accessibility to a computer with which to view the CD-Rom. The follow-up focus group captured the concern that some

community members felt about being able to access a computer. For this study, community members viewed the CD-Rom on one of two office computers which are normally reserved for employees. Given that the Tungasuvvingat Inuit Family Resource Centre (IFRC) has only one computer that community members can access, concern about accessibility is valid. If additional CD-Rom materials are to be developed, it will be essential to ensure that the IFRC has the necessary equipment to support their use.

Overall, the evaluation of the CD-Rom was positive and indicates that CD-Rom technology has strong potential as a medium for health information sharing in this urban Inuit community. Additional research is needed to assess the impact the information has on participants' experiences with pregnancy and prenatal care, and whether attitudes or behaviours changed as a result of having viewed the CD-Rom. The technology itself represents a practical and cost-effective way to connect community members in urban areas with Elders in the north. During the course of this research project, community members expressed a desire for additional health promotion materials, and several participants articulated an interest in materials about parenting young children. Such responses point to the need for a further exploration of Inuit parenting—an exploration that is framed more broadly by the family-centered and wholistic understandings that emerged in this study.

Family health and well-being: A closer look at parenting

Results from the second study illustrated the family-centered and wholistic nature of health for Inuit participants. The CD-Rom focused on maternal well-being during pregnancy and presented teachings from a family perspective by making specific mention of the roles of the mother and father, as well as other family members. Messages provided information on how the family can support the well-being of the mother and infant during the prenatal and postnatal period. Furthermore, although the message was focused specifically on pregnancy, it was nonetheless deemed relevant by the sample of participants who were at various life stages.

Research examining health with American Indian populations has also found that use of a family-centered perspective is relevant for Aboriginal peoples. Burhansstipanov and Hollow (2001) reported that the entire family was involved in the treatment and recovery of American Indian cancer patients. They also noted that the family was keenly involved in decisions, and that decision making was collective in nature and not based on patient autonomy. In another study, Burhansstipanov and colleagues (2005) reported that messages about breast cancer for American Indian women needed to emphasize the benefits to the family and community rather than personal benefits. For example, “Be a well woman” was not ideal, instead “Be healthy to teach your daughters how to be good women” was preferred. In Canada, the Ontario Aboriginal Healing and Wellness Strategy includes a framework which incorporates the life cycle, wholistic health, and a continuum of care (Government of Ontario, 2004). Together this suggests that for Aboriginal people, health is examined at a family level, as opposed to an individual level. Thus, it appears

that the family focus articulated by the Inuit in Ottawa is consistent with other Aboriginal groups.

This family-focus on health and well-being has also been evidenced in conceptual approaches to population health. Researchers introduced the concept of a 'life cycle approach to health' or 'life course perspective on health'. Tinker and colleagues (1994) have described the life cycle approach to women's health which involves examination of both the specific and cumulative effects of poor health. The approach acknowledges that different problems will affect women across the life cycle, but also points to the necessity of transmitting health information at early stages. For instance, a focus on counselling young and adolescent girls about nutrition, will help prevent health problems in later life. Barker (1998) has further suggested that events and exposures during fetal life have a lasting effect and contribute to health problems at a later time. In light of this, researchers have suggested that prevention programs develop a 'life course perspective' to health, for instance recommending a health-promotion environment for mothers prior to pregnancy (Barker).

Results from Study 2 showed that participants were interested in the health and well-being of young families. This is, in part, not surprising given that the project was based at the Tungasuvvingat Inuit Family Resource Centre, which houses programs specific to pregnancy, infants, and toddlers. Participants reported a specific interest in health information about child-rearing and parenting for young children. The Elder from the CD-Rom also reported an interest in creating a collection of CD-Roms that would address family health for infants and young children beyond the prenatal phase. At present, very little is known about how Inuit parents promote their children's well-being

beyond the infancy period. Documenting the nature of positive parenting within this community would represent an initial step toward understanding how urban Inuit parents support the well-being of their children. This knowledge would be beneficial for understanding the health and well-being of the Inuit children and community in Ottawa.

Study 3

Examining evidence for autonomy and relatedness in urban Inuit parenting

Introduction

Psychologists' study of parenting and culture is a relatively new endeavour. Early research was largely conducted by anthropologists (Harkness & Super, 2001), and it was not until the 1960s that psychologists began cross-cultural examinations of existing child development theories (e.g., Piagetian). The move away from comparative examinations of cultures occurred with the emergence of the discipline of cultural psychology, considered to be a middle ground between psychology and anthropology (Kral, Burkhardt, & Kidd, 2003). However, little psychological research to date has examined parenting in Inuit communities, and none has assessed Inuit parenting using a theoretical model. Furthermore, with increasing urbanization Inuit are settling in urban areas in the south, and it is unclear how their parenting beliefs and practices have been affected by the change in geographic, social, and family contexts. The present study sought to describe the parenting of urban Inuit in Ottawa and examined findings using the relatedness-autonomy dimension of culture (Kagitcibasi, 1994; Rothbaum & Trommsdorff, in press).

Parenting in Inuit communities. The literature on Inuit parenting provides consistent accounts from two main sources: academic researchers and Inuit organizations (e.g., Pauktuutit Inuit Women's Association). Two academic researchers, Briggs and Sprott, spent considerable time observing and documenting child-rearing and emotion socialization of Inuit children in Canada and Eskimo⁷ children in Alaska, respectively (Briggs, 1972; Briggs, 1985; Briggs, 1990; Briggs, 1995; Sprott, 1994). Together, the

⁷ Although the term 'Eskimo' is considered incorrect and offensive (Pauktuutit, 1990), Sprott and other mainly American writers continue to use this term. In the current document, the use of this term is limited to descriptions of Sprott's research.

work of the academic researchers and Pauktuutit identify three main themes. First, nurturance and attachment are central to the adult-child relationship. Infants and small children are tenderly and sensitively nurtured, and are the recipients of much affection. They are the centre of attention for both the immediate and extended family and all their material needs and wishes are fulfilled. Briggs (1995) observed that nurturance could exist in the extreme, wavering between overprotective and harsh behaviours. Parents were observed to control the lives of children, while also at times treating children harshly by not providing everything a child wanted or needed, or by scolding them instead of giving them affection. Parents were thought to act in such 'harsh' ways as a means to combat their fears of abandonment (i.e, if the child would die, they would miss him less). Such behaviour was also thought to promote autonomous development in their children.

Second, autonomy and independence are also central to parent-child interaction. Parents view children as the initiator of socialization and accordingly parents look for signs within their children to direct their responses. For instance, breastfeeding and toilet-training occurred when infants provided cues to the parents, as opposed to being based on parents' agenda (Pauktuutit, 1990). Autonomy is also measured individually, based on what children are able to accomplish, instead of whether children have attained a certain expected level of development. As a result, parents tailor their approaches to meet their children's abilities. Parents also accord much freedom to children, allowing them to engage in almost any activity so long as there was no risk of harming themselves (Pauktuutit, 1990).

Third, when instructing children, Inuit parents rely on observation and interpersonal games to promote learning and development (Briggs, 1985). It has been widely documented that Inuit children learn through observation as opposed to direct instruction and questioning by the child. Accordingly, observation is a method used to promote learning of skills by children. Interpersonal games are used to promote the emotional development of children. The games, which outsiders might regard as ‘teasing’, are used to alert children to emotionally charged situations, to arouse appropriate emotions for the situation, and to provide practice in dealing with such emotions. These games are tailored to each child, focusing on the emotional needs or problems of a particular child and often involve humour and indirect statements. For instance, a parent might say “This is the last candy, eat it quickly without telling your sisters”. Such a statement would be made to a child who has not yet learned to be generous, leading them to focus on the reasons and consequences of their actions. A child having difficulty controlling aggression might be told “Pull her hair!” to highlight the aggressive tendencies and thereby foster greater control. Adults would make such statements to arouse the appropriate emotions, like selfishness and anger, for the lesson they were seeking to socialize. This was hypothesized to teach children to recognize the danger in expressing those feelings, so that parents could then provide them with ways to develop healthy and appropriate responses (Briggs, 1985).

When these parenting characteristics are examined from the perspective of parenting style typologies, some researchers have suggested Inuit parenting can be characterized as ‘permissive’, given that Inuit parents show high levels of parental warmth or responsiveness and low levels of parental control (see for a review Sprott,

1994). Such a conclusion is inappropriate given that typologies were based largely on middle-class, North American, Caucasian families (Stewart & Bond, 2002). Other researchers have instead suggested that specific dimensions (e.g., control) could be examined across cultures. Such a recommendation likely represents the struggle of socialization researchers to balance their two goals: Understanding culture specific-behaviours and identifying universals across cultures (Sorkhabi, 2005). The former goal represents an *emic* or *relativist* approach, which focuses on the scope of cultural variation, the need to understand the unique phenomena within any given culture, and to study cultural groups on their own terms. The latter goal represents an *etic* or *universalist* perspective, which looks for universals that are ‘true’ across cultures and focuses on the differences in levels of certain dimensions and categories across different cultural groups (Dragnus & Tanaka-Matsumi, 2003).

Contrasting etic and emic approaches to models of parenting across cultures.

Stevenson-Hinde (1998) proposed a model which examines the bidirectional links between: (i) parenting cognitions (beliefs about parenting, the child, or oneself as a parent); (ii) parenting practices (strategies undertaken by parents to achieve specific outcomes) and style (constellations of parent-child interactions); and (iii) child outcomes. She stated that cognitions are sensitive to cultural norms, and dimensions of parenting style are relatively similar across cultures. However, there has been limited support for the latter proposition. Constellations of characteristics (i.e., styles) are, in fact, not the same across different cultural groups. For instance, although authoritarian parenting was negatively associated with warmth in child-rearing interactions in Western-European

Canadian samples, no such association was found in a sample of Egyptian Canadians (Rudy & Grusec, 2001).

It is also the case that the associations between parenting styles and child outcomes are not the same across different cultures. Authoritarian parenting in Chinese families is associated with higher academic performance, whereas in American families it is associated with poorer academic performance (Dornbusch, Ritter, Leiderman, Roberts, & Fraleigh, 1987). Furthermore, the beneficial effects of authoritative parenting have not been found in all studies of Chinese families (Chao, 2000, 2001). In light of these discrepancies, researchers caution against the importing of theories and concepts from one culture to another (Stewart & Bond, 2002). Chao (1994) suggested that parenting styles reflect certain historical influences and beliefs specific to one culture.

Consequently, because the history is not shared by those from other cultures, it would be inappropriate to apply them to other cultures.

In light of the difficulties in making direct comparisons between cultures, another line of research has instead sought to identify the parenting characteristics of various cultural groups. Many theorists and researchers have used the dimension of individualism-collectivism as a framework for examining variations in cultures.

Individualist cultures consider individuals to be independent from one another and emphasize personal autonomy and self-fulfillment (Hofstede, 1980; Triandis, 1995).

Collectivist cultures place the group's needs before individual needs and there is an emphasis on maintaining harmonious relations (Markus & Kitayama, 1991; Triandis, 1995).

Using this dimension, researchers have been able to identify different patterns of parenting based on whether cultures are individualist or collectivist (Chao, 1995; Harwood, Schoelmerich, Schulze, & Gonzalez, 1999). It is well documented that in collectivist cultures, including Japan, China, India, and Turkey, socialization focuses on interdependence (Kim, 1994). For instance, in Japan values that emphasize the group are achieved through parenting practices such as prolonged body contact between mother and infant and teaching of empathy for others (Edwards, 1995; Keller et al., 2004). In an examination of mother-preschooler play behaviour, American mothers emphasized autonomy and separateness of self from other, whereas Japanese mothers emphasized relatedness of self and other (Dennis, Cole, Zahn-Waxler, & Mizuta, 2002). However, the researchers noted that both cultures showed a certain coexistence of autonomy and relatedness.

Limitations of the individualist-collectivist continuum as applied to Indigenous cultures.

Indigenous cultures, and specifically Inuit communities, have been characterized as collectivist as the welfare of the family and community is considered more important than that of the individual (Briggs, 1985). Research examining this dimensional model of parenting with Indigenous peoples is sparse. Javo, Ronning, and Heyerdahl (2004) compared the parenting characteristics of majority Norwegians and the Sami, a traditional hunter-gatherer collectivist society of minority people living in the circumpolar regions of Russia, Finland, and Scandinavia. Although Sami parents focused on preserving in-group harmony, they also placed a strong emphasis on individual autonomy, internal self-control, and children's independence. The authors contend that their findings contradict the notion that individualism and collectivism are opposite ends of one dimension. Thus,

Sami parenting contains elements associated with both individualist and collectivist cultures.

It appears that the simple conclusion that Indigenous cultures are collectivist is problematic, given the importance of individual autonomy (McShane, 2005; Rogoff, 2003). Similar findings have emerged from research with other presumably collectivist cultures (e.g., Freeman, 1997; Rogoff, 2003). Reviewing the research on Aboriginal communities, McShane stated:

Aboriginal communities have typically been described as collectivist, with researchers citing the emphasis of getting along with others, reliance on the social group, and shared child-rearing responsibilities as evidence. However, it has also been particularly perplexing to me that the label is applied categorically in light of certain features of Aboriginal culture described by Brant and others. Specifically, one feature of Aboriginal cultures is the ethic of noninterference which places a high degree of respect for each individual's autonomy. Yet, this is a hallmark feature of individualism, and not collectivism. How can one reconcile this?

Researchers have recently suggested that perhaps cultures are better described along two dimensions: relatedness and autonomy (see Rogoff, 2003). *Relatedness* encompasses love, attachment, mutual obligations, and belongingness; whereas *autonomy* refers to personal choice, self agency, and psychological independence. In particular, researchers note that Native Americans foster autonomy through noninterference, which is designed to promote empathy, valuing of harmony and other cooperative characteristics. In turn, these characteristics would support

relatedness by building community integration and mutual supportiveness. In other words, Native American cultures evidence high levels of both relatedness and autonomy, and their cultural practices promote these values as complementary, rather than antithetical. Therefore, instead of applying the 'collectivist' label, the use of both relatedness and autonomy dimensions allows for more accurate representations of Aboriginal culture. (p. 1)

The constructs of relatedness and autonomy have been further examined as a means to reconcile theory with the observations. First described by Kagitcibasi (1994), *relatedness* encompasses love, attachment, mutual obligations, and belongingness; whereas *autonomy* refers to personal choice, self agency, and psychological independence. This model allows cultures and communities to vary on both levels of autonomy and relatedness. Rogoff (2003) stated that respect is accorded in interdependent Aboriginal communities in Northern Canada, suggesting that these communities are high in both autonomy and relatedness. This is consistent with Briggs' (1972, 1985, 1990, 1995) and Sprott's (1992, 1994) descriptions of Inuit parenting, which places high importance on both nurturance and respect for children's autonomy. In sum, the dimensional approach of relatedness and autonomy may provide a better framework for conceptualizing the parenting of Inuit.

Researchers have further examined the dimension of relatedness and have suggested that there are two types of relatedness: general trust, considered a form of relatedness that is compatible with autonomy, and assurance, considered inversely related to autonomy (Rothbaum & Trommsdorff, in press; Yamagishi, 2002). *Trust* is defined as 'a hope and faith in others whom one has chosen' as associates (Rothbaum &

Trommsdorff), and includes verbal intimacy, self expression, and confidence in self and other. *Assurance* is defined as loyalty and reciprocity, and involves group belongingness, empathy, harmony, loyalty and duty (Rothbaum & Trommsdorff). Trust appears to resemble the respect for autonomy and non-interference often observed in Aboriginal and Inuit communities.

Examination of parenting in an urban Inuit community. The previously reviewed research on Inuit parenting pertains to Inuit living in the north. It is unclear how similar or dissimilar parenting in an urban context will be to parenting in a northern, subsistence-based context. As described in McShane et al. (2006), the urban Inuit population is predominantly female, resulting in fewer fathers living in Ottawa and more single mother households. In addition, participants also reported that their family network were somewhat fragmented as their Elders and other family members were up north. Thus, it is possible that patterns of relatedness (specifically accessing family networks) will be diminished, reflecting the changes in family structure. However, it might be the case that parents are making significant strides to compensate for such geographic constraints, and patterns of relatedness would be high.

One research study conducted with First Nations living in urban centres examined differences in self-rated levels of independence and interdependence, according to strength of heritage culture (e.g., connection to Aboriginal cultural traditions). First Nations students with a high heritage culture reported higher levels of independence, when compared to First Nations with low heritage culture (Cheah & Nelson, 2004). This would suggest a positive association between independence and connection to culture.

However, it is unclear if this finding is related to the urban setting or solely related to strength of heritage culture.

In addition, very little research has examined the effects of colonization on Inuit. Inuit suffered much of the same oppression encountered by First Nations, such as suppression of language, residential schools, and domination. Fifty years ago, most Inuit in the north lived a traditional lifestyle centered on nomadic hunting and their culture remained relatively intact (Pauktuutit, 1990). However, forced sedentarization and subsequent change to settlement-based living, has significantly changed the life of Inuit families (Pauktuutit). Some Inuit parents in the north feel that one of the biggest changes in family life was the construction of walls at home (M. Kral, personal communication, November 1, 2005). Whereas in the past families lived together in one room, forced sedentarization has brought about the construction of homes with separate rooms which could possibly affect relatedness or autonomy in Inuit families. Thus, although not the focus of this study, it is necessary to recognize the potential impact colonization on Inuit parenting.

Objectives. In order to conceptualize the parenting of Inuit, an approach compatible with the emic perspective was employed. This involved open-ended interviews with parents and grandparents. The aim was to describe Inuit parenting on its own terms (i.e., with no preconceived coding scheme). This approach has previously been used in health research with Inuit (Archibald, 2004) and the Sami (Javo, Alapack, Heyerdahl, & Ronning, 2003). There were two main objectives: (1) Describe the parenting experience of urban Inuit. This information would be of unique value given that reports on Inuit parenting have been based exclusively on Inuit living in the north. (2)

Identify parenting themes of Inuit in terms of relatedness and autonomy. Although this study was descriptive in nature, I proposed two specific hypotheses. Based on Inuit parenting in the north (Briggs, 1985, 1995; Pauktuutit, 1990; Sprott, 1992), I hypothesized that some parenting themes would be linked to autonomy. For example, parents were expected to report respecting their child's development or to describe how they tailor their actions based on their child's age or characteristics. I also expected to find evidence of relatedness in the parenting of urban Inuit. Specifically, I expected themes would be related to nurturance and love, and family and community commitments. With respect to the relative level of relatedness and autonomy, no specific predictions were made given the myriad of possibilities that living in an urban environment might have on Inuit parenting.

Method

Participants. Individuals were recruited from the Tungasuvvingat Inuit Family Resource Centre, in Ottawa. Potential participants were initially identified by the community research team members. Identified individuals were provided with a description of the study and then were invited to participate if they were interested. As the goal was to gather information on parenting, parents of all ages were invited to participate. Thirty-nine adults were recruited to participate in the study ($M=39.31$ years; $SD= 12.46$ years). This sample included 8 males and 31 females. All individuals from the sample were parents and 13 individuals were grandparents.

Procedure. This study was conducted as part of a larger study examining health information processes. Refer to Study 1 and 2 for a more detailed description of the development of the partnership with Tungasuvvingat Inuit Family Resource Centre and a

description of the participating community. This study was approved by the Health Sciences and Science Research Ethics Board at the University of Ottawa.

Data collection was completed at the initial data collection time point (*Pre*) for Study 2. Questions were posed at the very beginning of the interview portion of the data collection, so responses to the parenting questions would not be influenced by responses to the questions pertaining to Study 2. Participants were asked the following three questions:

1. Tell me what it is like to be a parent or a grandparent.
2. What do you see as special in your children or grand-children?
3. How do you support your children or grandchildren?

Participants were given the choice to complete the interview in English or in Inuktitut. For those participants who indicated a preference for completing the interview in Inuktitut, one of two trained community research team members used a translation of the questions. Twenty-seven individuals completed the interview in Inuktitut and 13 completed it in English. Responses were audio-recorded and later translated and transcribed.

Coding. Data analysis used a mixed iterative editorial and immersion/crystallization organizational approach (Crabtree & Miller, 1992), previously used in Study 1 and 2. Initially, the coding was completed by two trained academic researchers who listed the most poignant themes of the community's parenting descriptions. A meeting was then held with the community research team members to discuss and adapt themes. Following this, the two academic researchers took these preliminary themes and conducted a more detailed analysis of the transcripts to

synthesize a coding scheme. The coding scheme and definition of codes are provided in Appendix J. Using this coding scheme, the principal coder coded all transcripts and the reliability coder coded 20 randomly selected transcripts for the frequency of each of the themes. Inter-rater agreement was calculated using intra-class correlations and was found to range from $r=.72$ to $.96$ (see Table 5).

A second coding scheme was developed for three broad thematic categories (child characteristics, behaviours, and beliefs). Two academic researchers read through the examples of the broad thematic categories and identified similarities to form a coding scheme that organized the broad categories into meaningful and exclusive sub-categories. The coding scheme and definitions of codes are provided in Appendix K. Using this coding scheme, the principal coder coded all transcripts and the reliability coder coded 20 randomly selected transcripts. For each instance of a child characteristic, behaviour, and belief, each coder independently assigned it to one of the sub-categories. Inter-rater agreement was calculated using Cohen's Kappa and was found to range from $\kappa=.73$ to $.92$. Disagreements were discussed and codes were revised for inclusion in the analysis.

A third coding scheme was developed for classifying the parenting themes using the constructs of relatedness and autonomy. The coding scheme was developed based on definitions provided by Rothbaum and Trommsdorff (in press). Relatedness was defined as family-, group- or community-centered, promoting love, attachment, belongingness, caring, support (emotional), and loyalty. Autonomy was defined as individual-centered, promoting personal choice, self-agency, independence, and personal rights. An 'Other' category was used for themes which were not indicative of either relatedness or autonomy. The coding scheme and description of themes are included in Appendix L.

Table 5.

Descriptive Statistics of Parenting Themes (N=39)

	<i>N</i>	<i>M</i>	<i>SD</i>	Min.	Max.	ICC
Child characteristics	29	2.26	2.49	0	12	.89
Intelligent/Skilled	20					
Independent/Strong	13					
Nurturant/Considerate	8					
Happy	3					
Negative	3					
Other	12					
Behaviours	33	2.15	1.66	0	7	.76
Instruct/Teach/Guide/Talk	22					
Warmth/Supportive	18					
Basic needs (food, home, clothing, etc.)	10					
Control/Discipline	4					
Other	6					
Affection and love	29	1.79	1.69	0	6	.80
Contextual stressors	15	0.74	1.25	0	6	.72

Table 5, Continued

Descriptive Statistics of Parenting Themes (*N*=39)

	N	M	SD	Min.	Max.	ICC
Beliefs	22	0.67	0.70	0	3	.76
Responsibility/Challenge	13					
Relationship-focused	6					
Competence	1					
Other	2					
Responsive and Respectful	12	0.67	1.24	0	5	.80
Support individuality	11					
Mutual partnership	3					
Negative emotions	12	0.36	0.58	0	2	.89
Anxiety/worry/fear	9					
Anger/frustration	3					
Concern about child's health	8	0.28	0.65	0	3	.94
Proactive (health Promotion efforts)	4					
Reactive (difficulty/worry)	4					

Table 5, Continued

Descriptive Statistics of Parenting Themes ($N=39$)

	N	M	SD	Min.	Max.	ICC
Family and community	8	0.26	0.60	0	3	.78
Parent/grandparent differences	4	0.26	0.91	0	5	.96
Future	3	0.10	0.50	0	3	.70
Child age differences	3	0.08	0.27	0	1	.69

Note. ICC=Intraclass Correlation. N = Refers to the number of parents who reported at least one instance of the category or the subcategory. The subcategory numbers may exceed the category total because a parent could be counted once at the category level, and twice at the sub-category level as they reported more than subcategory. M = Refers the average frequency of occurrence of each category (number of occurrences divided by number of parents).

Themes with a mean of greater than .5 were selected for coding. These included: child characteristics, behaviours, affection and love, contextual stressors, beliefs, and responsive and respectful. Using the coding scheme, the two coders evaluated each occurrence of the theme, as indicative of autonomy, relatedness, or other. Examples of autonomy and relatedness for each theme are presented in Table 6. Inter-rater agreement was calculated using Cohen's Kappa and was found to range from $\kappa=.89$ to 1.00.

Disagreements were discussed and codes were revised for inclusion in the analysis.

Results

Thirty-nine interviews were transcribed and included in the analysis. Mean word length of interviews was 184 words, ranging from 21 words to 743 words. Table 5 contains the descriptive statistics for the 12 themes. For broad categories, sub-categories are also indicated. Themes are presented below, in descending order of frequency.

Child characteristics. Parents provided descriptions of their children's or adolescents' identity, personality, abilities, skills, temperament, or interests. Characteristic sub-categories included intelligent/skilled (e.g., athletic, artistic), independent/strong, nurturant/considerate, happy, and negative (e.g., stubborn). The 'other' sub-category contained a wide variety of child characteristics, including innocent, relaxed, beautiful, enjoys his Inuk culture, humorous, and gentle.

Behaviours. Parents described the specific support and actions they did to help their children. Sub-categories included warmth/supportive ("I am there for them"), instruct/guide/teach/talk ("Teach them to help others so they won't be selfish"), providing basic needs ("I support them financially"), and control/discipline ("Try to discipline them as much as I can"). The 'other' sub-category contained behaviours including prayers,

Table 6.

Examples of Themes Indicating Autonomy and Relatedness

	Autonomy	Relatedness
Child Characteristics	<i>Really independent already. They're just unique in their own way.</i>	<i>They are so special because they, our kids, they have our feature too</i>
Behaviours	<i>Give them lots of independence</i>	<i>Trying to make them feel good being a part of the family.</i>
Contextual Stressors	<i><parenting> it's costly, even cost your career</i>	<i>I didn't have my parents living with me because we were living in the south all the time.</i>
Beliefs	-	<i>To me they are my first</i>
Responsive and Respectful	<i>Let him do what he wants</i>	<i>I have to try to come with a solution with them, we both try to come up with something that we can both live with.</i>

using language to promote culture, fostering a sense of family membership, and providing choices.

Affection and love. Parents described a warm, connected feeling toward their child or toward parenting. They described parenting or their relationship with their child using positive adjectives. Examples include: “it’s rewarding”, “it’s a joy”, “I love it”, “I love them”, and “You feel proud”.

Contextual stressors. Parents mentioned economic stressors, personal health problems, work stressors, changes in social context, and children being placed in care (with Children’s Aid Society). Examples include: “I’m on welfare”, “I’m a single parent”, “My parents are not in the south”, “It <parenting> can cost you your career” and “That’s double for me, double job after working hours”. One mother spoke at length about the stress of having a child removed from home.

When you are a single mother they always try to take away your baby or you have to get married. If you do that, you have to give your baby away anyway. In order to keep the baby, if you’re a single mother, you have to talk to the city, otherwise they are always try to take away your baby.

Beliefs. Parents described their thoughts and cognitions about their role as parents. Statements included how they felt their child has influenced them, as well as the responsibility or challenging nature of their role. Sub-categories of beliefs were responsibility/challenged (“It’s a lot of work”), relationship-focused (“Without them my life would be empty”), competence (“I know I did an amazing job with them”), and ‘other’ (“They keep me busy”).

Responsive and Respectful. Parents described how their behaviours were tailored specifically to the child (i.e., are respectful and responsive to the child). Two sub-categories emerged, the first being supporting individuality. Parents discussed how they responded directly to their children's needs or how they tailored their behaviours to match their child's needs and abilities.

Like if they need comforting I'll comfort them, if they are hungry I'll feed them if they are hungry for snack I'll feed them, if they want simply hug or kiss I'll hug and kiss them, or if they want attention from me I'll listen to them.

We take what each of them like and try to make that. J. is a naturally athlete so and we are supporting him by getting him involved by soccer and swimming... C. doesn't want to do that, is more into arts so we get him to art classes things like that.

The other subcategory captured the mutual partnership or reciprocal help described in parenting interactions. Some parents spoke about how they respected their child and were able to engage in parent-child collaboration and compromise. Examples include: "We both try to come up with something that we can both live with" and "He had an intervention he took me out of the bingo, and I took him out of the bar".

Negative parent emotions. Fewer than a third of parents described parenting as a negative experience or about having a difficult relationship with their child. They reported frustration, anxiety, or anger with their role as parents or in their relationship with their child. Examples include: "It's frustrating", "I'm constantly worried", and "It's stressful".

Concern for child's health. Some parents reported worry about their child's health or difficulty in maintaining child's health. Some parents reported their efforts to keep their child healthy. Examples include "It's difficult, especially when they don't want to eat" and "Keep them in healthy shape".

Family and community. Some parents discussed the help and/or involvement of family members (other than spouse) or community organizations. This also included having accessed those resources, or simply indicating that they are accessible to the parents. Examples include: "if I can't do it alone I get someone who is more experienced to help me with it" and "to have parenting classes here at the resource centre really helped".

Parent vs. grandparent differences. Some grandparents mentioned differences between being a parent or grandparent, or indicated preferences to raising grandchildren as compared to children. Examples include: "I love my grandkids more than I love my own kids", "For my grandkids, because I am always twice as available", and "<being a grandmother> it's like being a mother but with more power".

Future. Few parents made reference to the child's future, or their plans and ideas about the future. Examples include: "Make a better future for them" and "I just really worry, also their future".

Age differences: Children vs. adolescents. Few parents mentioned differences in raising children compared to adolescents. Oftentimes they commented that raising young adolescents was more difficult than raising children or young adults. Examples include:

When they are getting older when they reach the age of 13 or 14, it gets harder lots of difficult thing<s> start coming especially now in 2005.

My daughter is 18. She is a lot better than when she was 13 or 14, so it's not that bad.

Statistical analyses. A series of chi-square analyses were computed to examine differences in frequencies in each of the twelve parenting themes, according to participant gender and grandparent status (no/yes). For these analyses, the parenting themes were recoded into a presence/absence code to allow for 2x2 analyses. For chi-squares examining differences according to gender, none was significant, all $\chi^2(1) < 2.60$, $p > .10$. One chi-square examining differences according to grandparent status was significant, parent vs. grandparent, $\chi^2(1) = 8.91$, $p < .01$. All participants who mentioned this theme were grandparents. Thus the thematic contents of the narratives do not appear to be a reflection of the individual characteristics, and may be considered reflective of the urban Inuit community in Ottawa.

Examination of autonomy and relatedness. The parenting themes that had a mean frequency of .5 or greater were then coded for reference to the constructs of autonomy and relatedness. Affection and love was identified as evidence for relatedness. The other themes child characteristics, behaviours, contextual stressors, beliefs, and responsive and respectful included a combination of autonomy, relatedness, and other. Table 7 contains the frequencies for themes according to focus.

A 6x3 within-subjects ANOVA with planned comparisons was used to test for differences in frequencies of themes (child characteristics, behaviours, affection and love, contextual stressors, beliefs, and responsive and respectful) according to focus

Table 7.

Frequency and Percentages of Themes Indicating Autonomy and Relatedness

	Autonomy	Relatedness	Other	Total Count
	N (%)	N (%)	N (%)	
Child Characteristics	18 (20.5)	12 (13.6)	58 (65.9)	88
Behaviours	3 (3.6)	19 (22.6)	62 (73.8)	84
Affection and Love	(0)	68 (100)	(0)	68
Contextual Stressors	1 (3.5)	14 (48.3)	14 (48.3)	29
Beliefs	(0)	6 (23.1)	20 (76.9)	26
Responsive and Respectful	22 (84.6)	4 (15.4)	(0)	26

(autonomy, relatedness or other). The overall multivariate test for a theme effect, based on Wilks' criteria, was significant, $F(5, 34)=8.77, p<.001$, partial $\eta^2 = .56$. The overall multivariate test for focus, based on Wilks' criteria, was significant, $F(2, 37)=28.76, p<.001$, partial $\eta^2 = .61$. A planned paired t -test was used to compare overall frequencies of autonomy and relatedness statements. The t -test found significantly higher frequencies of relatedness statements, $t(38)=5.32, p<.001$.

The overall multivariate test for an interaction effect between theme and focus, based on Wilks' criteria, was also significant, $F(10, 29)=11.31, p<.001$, partial $\eta^2 = .80$. Planned paired t -tests were used to compare autonomy and relatedness frequencies, for each of the six themes. The t -test examining differences in frequencies of affection and love was significant, $t(38) = 6.64, p<.001$. This result was expected as the affection and love category contained relatedness-focused statements exclusively. The t -test examining differences in frequencies of parenting behaviours was significant, $t(38) = 3.32, p<.01$, with a higher frequency of relatedness-focused parenting behaviours. The t -test examining differences in frequencies of parenting beliefs was significant, $t(38) = 2.23, p<.05$. There was a higher frequency of relatedness-focused parenting beliefs. The t -test examining differences in frequencies of contextual stressors was marginally significant, $t(38) = 1.84, p<.10$. There was a tendency for a higher frequency of relatedness-focused contextual stressors. The t -test examining differences in frequencies of responsive and respectful was significant, $t(38) = 2.28, p<.05$. There was a higher frequency of autonomy-focused responsive and respectful statements. Overall, analyses showed that, with the exception of responsive and respectful, most statements were indicative of a relatedness-focus.

Discussion

Characterizations of Inuit parenting have been limited to Inuit living in the north; very little is known about Inuit parenting in an urban context. This study sought to address this gap in the literature and further our understanding of autonomy and relatedness in a cultural context. The first objective was to use an emic approach to describe parenting in the Inuit community of Ottawa. The second objective was to identify parenting themes indicative of autonomy and relatedness. I expected to find evidence of both constructs, as this has previously been identified in descriptions of Inuit parenting in the north. I also did not make any predictions regarding the relative presence of autonomy and relatedness in the parenting descriptions of urban Inuit.

Some of the parenting themes identified in the current study were consistent with previous findings from the north, although unique themes were also identified. *Affection and love* was identified as a common theme and is comparable to nurturance and love described by Briggs (1995), Sprott (1992), and Pauktuutit (1990). *Family and community* was also identified, although it was not a very common theme. Thus, consistent with the hypothesis, there was evidence of nurturance and love in the parenting of urban Inuit. However, different from what was predicted, there was a less of focus on the family and community aspects of this. This might reflect isolation from family members who live in the north. For instance, it might be that the family and community links for support typically involved face-to-face contact, which was no longer possible given the distance. This could have impacted the close kinship networks that are common for Inuit in the north (Pauktuutit, 1990). In fact, McShane et al. (2006) found that some Inuit in Ottawa would routinely call family members in the north for advice on health care, suggesting

that Inuit in Ottawa are adapting their support-seeking methods as a result of the separation. Thus, it could be that the relatively low reporting of family and community supports in parenting represents the isolation separating family and community members.

Autonomy and independence were present in the parenting descriptions and were principally captured by the theme *responsive and respectful*. Although regarded as highly present in Inuit parenting in the north, it occurred half as frequently as the affection and love theme. Nonetheless, as expected, the most common parenting themes identified in the current study paralleled research findings from the north. Two other themes, *age differences* and *future*, were identified in a small proportion of transcripts. They can be considered reflective of autonomy as parents spoke about how their children behaved differently according to their age and how their children's future was largely self-determined and not adult-determined.

Overall, results showed that affection, love, family/community support, and autonomy were consistent across parenting in Inuit communities in the north and in urban areas in the south. These results were also consistent with observations made by Rogoff (2003) who stated that Inuit communities ensure that individual autonomy coexists in an interdependent social system. It was also consistent with findings from Javo et al. (2003) who examined parenting in the Sami community in urban Norway.

Another theme identified related directly to stressors. *Contextual stressor* was the fourth most common theme, and included financial stress, career stress, and stress related to family separation. Notably, some parents reported stress about having their children removed by the Children's Aid Society or stated that they did not presently have custody of their children. Other stressors related specifically to being in the south. Although the

current study did not explore the impact of such stress, there is some indication that it has impacted parents' transmission of language and culture, as well as resulting in decreased support for parents. As one parent commented:

...teenagers, they often lose their mother and culture and no wonder, we don't live up north, we are living in an urban area. Even though they don't speak the language, I try to speak to them as much as possible.

Some parents commented about the fact that their children were growing up in a multicultural society, unlike their own experiences growing up in the north. A few spoke directly about their children's mixed Inuit ancestry, suggesting that this was a source of stress. These particular stressors seem more common in an urban context, where inter-culture relationships exist. However, most parents spoke about their children's ability to negotiate the multicultural, multilingual world. This points toward the acculturation process and suggests that parents see their children as balancing between the heritage culture and the mainstream culture. This provides tentative evidence for a bidirectional model of acculturation (Ryder, Alden, & Paulhaus, 2000). However, it would be premature to make any conclusions, as the current research did not assess acculturation. Nevertheless, it suggests that Inuit parents are navigating through both Inuk and mainstream cultures.

Another stress-like theme was identified, *concern about child's health*, although this was not a frequent theme. A few parents spoke about how they keep their children healthy in general, and others spoke about being worried or concerned about their children's eating habits or their children's hunger. Although few in number, examples included both proactive and reactive statements. This suggests that for some Inuit parents,

parenting involves a focus on children's health. It is also apparent that health concerns extended beyond the pregnancy and infancy stage. Further work is required to pinpoint what behaviours are tied to specific health concerns, and how these behaviours might differ according to socio-emotional health concerns compared to physical health concerns.

The intergenerational effects of residential schooling on parenting, parent health and well-being have previously been documented for Inuit living in the north (King, 2006). In the present study, there were very few statements about the effects of colonization, sedentarization, or personal trauma. One parent commented that in the north mothers who have a substance abuse problem have their children removed in order to properly care for the children and allow the mothers to look after themselves. As mentioned previously, there was discussion about Children's Aid Society and the removal of children in the urban context. Together, this suggests that stress is a common part of the parenting experience of urban Inuit; yet, the effects of colonization and associated trauma on parenting remain unclear.

Given the documented links between parental health and parenting (e.g., Lyons-Ruth, Wolfe, & Lyubchik, 2000), additional research is needed to examine if and how these links exist for urban Inuit parents. Recent research with Aboriginal people in Canada found that when community health workers were asked about a focus for pregnancy and parenting, 'turning around' the intergenerational impact on residential school was considered key to this process (Smith, Varcoe, & Edwards, 2005). It should be noted that this work was conducted with Aboriginal people in rural areas; as such, it might not be applicable to Inuit in Ottawa. However, it does suggest that it is necessary to

focus on the impacts of family well-being and healing on of pregnancy and parenting. Thus, there is reason to suggest that the health of Inuit parents should be examined, as well as how it impacts the health of children.

The two most common parenting themes that were identified were child characteristics and parent behaviours. Given the breadth of these categories, it is not surprising that they were so common. It is possible that the high prevalence is an artefact of the questions that were employed to assess parenting, as two questions specifically addressed child characteristics and what parents do to support their children. These questions were selected to act as follow-up questions to the general parenting experience question in order to ensure adequate content coverage. It is likely that these two probes served to increase the frequency of the themes, not to introduce the themes.

Although present in previous reports on Inuit parenting, parenting behaviours such as interpersonal games were not mentioned in the present study. Javo and colleagues (2003) also reported a decrease in interpersonal games used by Sami parents in Norway. They suggested that the current generation of Sami parents may be less competent in this form of socialization and that it is not as effective as before. The reasons why Inuit parents in the current study did not report the use of interpersonal games are unclear. Parents most frequently reported warm and supportive behaviours, consistent with descriptions of Inuit parenting in the north (Pauktuttit, 1990; Briggs, 1970). It may be because questions were not focused specifically on how Inuit parents teach their children, although other means of teaching were described. Alternatively, given that the questions used in the study focused on supportive parenting, parents did not report these as they did not view them as effective.

Also prevalent were behaviours focused on providing the basic necessities for children (e.g., food and clothing). Previous work with urban Aborigines in Australia found that parenting values were ordered in a similar fashion to Maslow's hierarchy of needs (Nelson & Allison, 2000). That is to say, at the apex were parenting values and behaviours focused on the *survival* of children. The focus of Inuit parents on basic needs might be a similar pattern. However, Inuit parents reported a higher frequency of teaching and instructing behaviours, than actions to promote basic needs. This might be reflective of Inuit parents' broader focus on health; that is, not physical health alone, but also emotional, spiritual, and mental health.

When it came to teaching and guiding children, parents spoke about teaching a specific lesson (e.g., not being selfish) through direct communication with their children. These changes may reflect generational differences or the effects of acculturation. For instance, reduced contact with traditional models of parents and caregivers may have resulted in new models for parenting being used. Living in an urban non-Inuit city could result in the parenting model being focused on Western-based socialization techniques. Overall, it suggests that there are changes in the socialization techniques of urban Inuit parents.

Urban Inuit parents did not report the use of observation as a method for teaching their children. It is possible that the change in the specific behaviours further represents a shift as a result of the urban setting. For example, it could be that being in an urban centre results in more teaching being done through schools, and consequently less teaching done at home. In fact, Archibald (2004) reported that Inuit mothers and daughters no longer talked about sexuality as daughters were now educated at school on the topic. Another

explanation is that observational teaching was linked to traditional hunting and living on the land; as such, an urban setting does not offer an environment for this teaching to take place.

A third explanation, based on a combination of both reasons, is that observation is a traditional form of teaching, which has been lost as a result of historical forces which changed lifestyles from land-based to settlement-based life. (Alternatively it could be unarticulated.) This, coupled with the introduction of schooling, has been suggested to have disrupted the natural teaching mechanisms (Takano, 2005), thereby resulting in a dramatic decline in teaching by observation. If this were true, a similar shift in teaching methods by parents in the north would be expected as well, given the common historical experience. Nevertheless, the results point to relatively less teaching by observation in an urban context, although the specific explanation for such a change is currently unclear. It should be recognized that the current study did not ask questions specifically on teaching or instruction methods. Therefore, the lack of examples may be an artefact of the questions selected instead of changing in parenting behaviours.

Another parenting behaviour that was not evident in the current study was the harsh or overprotective parenting, previously described by Briggs (1995) as the extreme of nurturance. The few negative aspects of parenting that were reported chiefly reflected negative emotions, which largely focused on the anxious and stressful nature of parenting. Some negative beliefs were also reported, but these focused on the challenging nature of parenting. In addition, few negative child characteristics were mentioned. The rarity of negative emotions, namely anger, is consistent with Inuit emotion socialization (Briggs, 1970). Briggs has observed that the expression of anger is largely condemned in

Inuit communities. Thus, the low frequency of negative parenting descriptions may be reflective of prevailing social norms for emotion expression. It might also be that the restriction on negative emotion expression also encompasses expression of negative parenting behaviours. Accordingly, no reports of negative parenting behaviours would be expected to be shared.

An alternative explanation to the infrequent mention of negative parenting emotions and behaviours might be the questions that were employed. The focus was on how Inuit parents *support* their children and grandchildren. Thus, parents may not have reported negative emotions and behaviours because these do not support their children. This could suggest that parents do not see these practices as adaptive, despite observations made by Briggs (1970). Additional research which examines the links between parenting and children's well-being is needed to confirm this suggestion.

It is noteworthy that mothers and fathers reported similar frequencies of themes. The only difference identified between grandparents and parents was the report of experiences as grandparents, which is fundamental to the theme. This suggests that characteristics of identity on an individual level, are not powerful determinants of parenting. It suggests that the parenting experiences are consistent amongst community members, and lends credence to the notion that parenting can and should be described from a community perspective.

Evidence for autonomy and relatedness. As predicted, parenting themes of urban Inuit parents evidenced both autonomy and relatedness. Overall, the most prevalent themes were more often indicative of relatedness. Affection and love was a single category which evidenced relatedness, and the majority of frequencies in the behaviours,

beliefs, and contextual stressors categories also were linked to relatedness. Affection and nurturance crossed many categories; parents described their children as nurturant, stated they used warmth and supportive parenting behaviours, and possessed parenting beliefs related to the impact their children have had on their lives.

Notwithstanding, one relatedness theme was actually not prevalent, contrary to predictions. Family and community support was not commonly reported, occurring on average in one quarter of the transcripts ($M=.26$). Inuit and Aboriginal families and communities have consistently been found to have closer family relationships and stronger social networks than non-Aboriginal families (e.g., MacPhee, Fritz, & Miller-Heyl, 1996; Pauktuutit, 1990). This suggests that the behaviours and characteristics typically associated with the relatedness dimension may actually be different for urban Inuit. That is to say, although urban Inuit parenting can be characterized as high in relatedness, the actual behaviours reflect behaviours in the parent-child relationship (e.g., affection and love) and not in relationships amongst families or communities (e.g., mutual obligations between families). This could reflect the fragmented family relationships as a result of living in urban areas in the south. The fact that contextual stressors were linked to relatedness may in fact reflect such changes. However, the current study cannot ascertain whether this proposition is true of urban Inuit parents. In addition, it may be that parents are not articulating reliance on families and communities for parenting support as it is so ingrained in their approach.

An alternative explanation is that there are two sub-types of relatedness, this would support initial propositions made by Kagitcibasi (2005) and Rothbaum and Trommsdorff (in press). Research that seeks to better define and distinguish the construct

of relatedness in Inuit communities would be able to address this intriguing proposition. The presence of affection, love and nurturance appears indicative to the construct of trust, whereas the community reliance (albeit not frequent in this study) appears indicative of assurance. It is possible that assurance is low due to fragmentation of the communities and the lack of traditional land-based communal activities which may have had a substantial impact on group belongingness.

Autonomy was also evidenced in urban Inuit parents' experience, albeit to a lesser extent. The parenting theme of responsive and respectful was linked to autonomy. Parents reported their desire to match their behaviours to their children's characteristics; in essence, they employed a child-specific approach in their parenting. Such tailoring has previously been linked to flexible parenting (Grusec, Goodnow, & Kuczynski, 2000). Although most other parenting categories were significantly linked to relatedness, parents also described their children as independent. This further supports the inadequacy of the collectivism/individualism conceptualization of cultures, as it limits the presence of both constructs. The concepts of autonomy and relatedness appear to better describe findings. In addition, two concepts of relatedness seem to have emerged in the current study. In all, the analysis revealed evidence for both autonomy and relatedness, suggesting that the bidimensional model of autonomy and relatedness is more appropriate.

Finally, the relatively low frequency of autonomy-focused themes is intriguing. Parents reported tailoring their behaviours based on their children's characteristics. However, the freedom and independence which has been described in parent-child relationships in the north (Pauktuutit, 1990) was not prevalent in the descriptions of urban Inuit parents. This might be because the urban environment has more dangers than in the

north. It might also be because in the north the kinship support system is strong and large, allowing other adults to ‘keep an eye’ on children, thereby protecting them from danger. Thus, parents might be adapting their strategies based on the context to ensure the health and well-being of their children.

Conclusions. This study represents a first attempt at using an emic approach to describe and characterize parenting in an urban Inuit community. Results are both similar and unique to parenting characteristics previously identified in Inuit communities in the north. Relatedness and autonomy were both evidenced in the current study, as well as contextual stressors. A lingering question remains as to whether the current findings on urban Inuit parenting are reflective of the urban context alone, the broader socio-historical changes, or both. Further examination of Inuit parenting in the north would help clarify whether the current parenting trends are indicative of a change from land-based to settlement-based life, and would also help clarify whether there are additional changes as a result of living in a southern, urban centre.

General Discussion

This collection of studies examined family health and parenting of urban Inuit. The principle objective of the research was to describe and document family health and parenting of the urban Inuit community in Ottawa. Health and well-being were conceptualized from a family-centered and wholistic perspective. The research was community-based and completed in partnership with the Tungasuvvingat Inuit Family Resource Centre, using a participatory action research approach. The goal for each study was to focus on community-specific understandings of family health and parenting. Working with the community ensured research materials and evaluation tools were culturally-relevant and congruent with learning preferences of community members. Throughout the series of three studies, valuable information was obtained on health information processes and parenting of Inuit in Ottawa. In addition, the descriptive information on health processes provided the necessary foundation on which to create and evaluate a locally-tailored health promotion tool.

The first study examined health information sources and dissemination strategies. A community-specific perspective on health information sources and dissemination strategies was devised and found to be dissimilar to mainstream health information sharing mechanisms. The major sources of health information were from within the Inuit community, principally through Elders, family, friends, staff of the Inuit Family Resource Centre, and family doctors. The major dissemination strategy was one-on-one communication, and was linked to the strong cohesive community structure. Themes surrounding access to health care and information were also identified. Community members reflected on the natural Inuit way of information exchange, through seeing or

speaking. Such an observation addressed specifically the preferred medium for health information sharing. Recognition of the importance of Elders was also expressed; they were involved in decision making in the area of health. This, coupled with the fact that Elders were a significant source of health information and dissemination strategy, pointed to the pivotal role of Elders in health information processes. A distinction between Inuit-specific information, and mainstream-information also emerged, with a preference being indicated for the former. Finally, there were several comments about the need for cultural interpreters to help navigate the health information system. Together, these articulated preferences and naturally occurring health information processes formed the basis of the development of a new health promotion tool.

The second study used this community-specific information to develop and evaluate a new health promotion tool focused on maternal well-being and pregnancy. The topic and message were selected by an Inuk Elder and were presented in a bilingual (Inuktitut and English) CD-Rom. Overall, the CD-Rom was well-received by the community members. Increases in responses were noted for: likelihood to recommend the CD-Rom to someone; similarity of the CD-Rom to talking to someone; and message clarity. Qualitative data showed that initial concerns about the use of technology were allayed, although some members expressed concern about using the CD-Rom outside of the Tungasuvvingat Inuit Family Resource Centre where computers would be less accessible. Community members particularly appreciated the wholistic messages and that it was an Inuk Elder who presented the message. While the focus was on the oral and visual content of the health promotion tool, community members made comments about improving the quality of the accompanying text. Thus, it appears that although the focus

may be on the visual and oral means of communication, written information presented in this context should be viewed as equally important. Finally, community members expressed a desire for information on additional topics, notably childrearing, presented through the same medium. This suggests that the health and well-being of infants and young children is a priority for community members.

At present there is no information on what urban Inuit parents do to support the health and well-being of their children. The third study explored this area by examining the parenting descriptions of the community members. Building on existing cultural theories, parenting descriptions were examined for evidence of relatedness and autonomy. As expected, parenting contained elements of both relatedness (e.g., love and affection) and autonomy (e.g., responsive and respectful). Parenting themes were more often linked to relatedness than to autonomy. These results were largely consistent with previous research conducted with Inuit in the north (Briggs, 1995; Pauktuutit, 1990; Sprott, 1992). However, some unique features emerged, suggesting that socialization practices of urban Inuit are changing. Although relatedness is often evidenced by family and community connections, this was not as strong in the urban setting. In addition, interpersonal games and teaching through observation have been reported as Inuit parent behaviours, but they were not reported by parents in this study. This study provided a formative account of parenting of urban Inuit and provided some direction for future family-centered, health promotion projects.

New Directions for Urban Inuit Health Research

Prior research findings on the health and well-being of Inuit were limited to those living in the north (e.g., Thouez et al., 1990; Sprott, 1992). In addition, no health

promotion materials had been developed specifically for urban Inuit, and none had been formally evaluated. This collection of studies has yielded not only valuable descriptive information about urban Inuit health, but is also the first evaluation study of an urban Inuit health promotion tool.

Family-centered and wholistic approaches. Results from the present studies suggest that a family-centered and wholistic perspective on health is shared by urban Inuit. In Study 2, a focus on the mental aspects of pregnant women's health and discussion of pregnancy and the role of family members were appreciated. In Study 1, participants reported that a major source of health information was from family members and Elders. In all, this suggests that family-based models of health, which encompass wholistic aspects of health and examine the well-being of families, are most consistent with urban Inuit perspectives on health.

The use of family-based models of health for urban Inuit has implications for service provision and the types of health services. Families, and not one individual, will become the 'client'. As a result, practitioners will need a broad skill set base, including knowledge of health and well-being across the lifespan and in different domains (i.e., physical, mental, emotional, and spiritual). This will likely be only accomplished through multidisciplinary healthcare teams, comprised of Elders, traditional healers, physicians, and mental health professionals. Hence, a prenatal program would be taught by a team, and would focus on more than developmental milestones based on physical abilities. Such programs require extensive coordination and should strive to offer a continuum of care, which has previously been articulated by Aboriginal Health policy makers (Government of Ontario, 2004).

Health promotion materials. The community-specific perspective on parenting also suggests the need for changes in the development of health promotion materials. If parenting messages are presented based on strategies and techniques of parents in the north, then they might appear dissimilar to current prevailing parenting approaches in the urban context. Accordingly, a community-specific approach that recognizes the cultural and geographic context of urban Inuit parents will likely increase acceptance and, consequently, the success of interventions. Further examination of what parents do to support their children's health and well-being could yield community-specific information that can be included in health promotion stories. Local success stories, helpful tips, and family experiences are all likely to be well-accepted by the urban Inuit community given their articulated preferences from Study 1.

Results from Study 2 found that the key factor to the success of the CD-Rom was the fact that the information was presented by an Inuk Elder, as well as the community involvement in the project. It appears that in this urban Inuit community, there is a desire for traditional Inuit knowledge. Individuals valued the Inuktitut words they learned, the Elder's amauti, and being able to read her body language. Together, these comments suggest that CD-Rom technology offers an avenue to capture and communicate the Inuit culture. It is unclear how much of the success of the CD-Rom was related to the presence of the community facilitator.

Although the CD-Rom appears to be an effective health information tool, an evaluation of the retention of the information and the influence of the information on future health behaviours and attitudes remains to be completed. If future CD-Rom health information tools focus on early detection of childhood diseases (e.g., respiratory viral

infections), a longitudinal study could examine the incidence rates, as well as emergency room visits. This type of health promotion tool is being proposed in new research projects with the community, which would be integrated with access to family physicians and front line health care workers. Having documented that this type of tool is considered positive by the community, this second tool can evaluate changes in health behaviours and disease course, as well as the impact of the community facilitator.

Parenting in urban Inuit communities. The results of Study 3 indicated that Inuit parenting in an urban context may involve new socialization experiences and techniques. Stressors were a frequent element in parenting descriptions and were sometimes linked to aspects of relatedness involving connections to extended family relationships. This echoed the finding in Study 1 that some participants would call family members who lived in the north to discuss health problems, but that they had difficulty connecting with Elders because many lived in the north. When information was needed on parenting, for the day-to-day challenges with their children, Inuit parents appear less inclined to consult other family members. It is unclear if Inuit parents are both not soliciting advice and help from family in Ottawa, and refraining from accessing help from family living in the north. Nonetheless, it appears that Inuit parents in Ottawa are having to adjust their parenting approaches to reflect changes in resources. It is unclear if such differences are strictly related to the urban context, or if they may in fact represent generational changes. Furthermore, it is curious that participants reported family members as a main source of health information, but reported rather infrequent support from them for parenting.

The perspective gained on parenting has numerous implications for both research and health promotion. From a research standpoint, certain theoretical questions can be

posed about the nature of the relatedness construct. Recent cross-cultural work suggests that autonomy-relatedness models of parenting portray urban, educated, middle-class families in societies with an interrelated cultural heritage (Kagitcibasi, 2005). Thus, it is unclear how well, if at all, the Inuit community in Ottawa fits with Kagitcibasi's description of societies with autonomy-relatedness models of parenting. It could be that the defining features of these societies are not as specific as Kagitcibasi stated, or that Inuit and potentially Aboriginal parenting does not map on exactly to the model proposed. Nevertheless, such observations and discussion illustrate the many exciting questions that can be examined in attempts to better understand the conceptualization of autonomy and relatedness.

One line of questioning which emerged from the current project is whether Inuit parenting can be characterized with two constructs of relatedness. It would appear that Inuit parents promote relatedness on an individual level, by demonstrating love, affection, and nurturance. However, it appears that on a broader level, that they are relying less on family and community supports in their parenting interactions or they are not reporting it as it so ingrained. Although the dimensions of relatedness and autonomy allow for a more accurate viewing of parenting in a cultural context, as compared to the individualism-collectivism dimension, it appears that further development of these dimensions is needed.

The distinction between trust and assurance as two types of relatedness (Yamagishi, 2002) is a potential explanation for the findings. At first glance, Inuit parents reported examples of relatedness (e.g., nurturance, love) which were linked to trust, and not to assurance. However, it is unclear if the limited support for assurance is linked to

the urban context, generational changes, or some other factor. An alternative model proposed by Kagitcibasi (2005) further conceptualizes the dimensions of relatedness and autonomy. Her model proposes a dimension of personal agency (autonomy-heteronomy) and one of interpersonal distance (relatedness-separateness). When the two dimensions are crossed, four theoretical types of selves and families emerge. Results from Study 3 found urban Inuit parenting to be moderate to high in relatedness (accounting for the high nurturance and love), and moderate in autonomy (which was largely personal in nature). Her category of high personal agency (autonomy) and low interpersonal distance (relatedness) describes “a family model of psychological interdependence, with both (order-setting) control and autonomy orientation” (p. 413). Such a model appears generally consistent with results from Study 3, although it is unclear how or if order-setting control is descriptive of Inuit parenting.

Limitations

A significant strength of these studies could also be considered a limitation. The emic perspective that was utilized ensured that a community-specific understanding of family health and parenting was obtained. The goal of this research was not to make comparisons to other populations. A consequence of the community-specific focus is the lack of generalizability of the findings. The findings may well be applicable only to the Ottawa Inuit community. Other urban Inuit communities may not have the same family-centered and wholistic view on health; this may depend on the size of the community or other factors.

The focus of Study 3 was to gather information on urban Inuit parenting. One of the questions was framed to elicit the supportive actions of parents. However, because

children's well-being was not assessed, this research could not fully ascertain how well urban Inuit parenting is working. In addition, as the parents who participated in the study were those who visited Tungasuvvingat Inuit Family Resource Centre (TIFRC), they may represent a subset of the Inuit population in Ottawa. Despite this, there are over 100 family records at the TIFRC (Connie Siedule, personal communication, December 12, 2005), suggesting that a significant proportion of Inuit living in Ottawa have been to TIFRC at some point.

Inuit in Ottawa make up a very distinct group of Inuit. Not only are they city-dwellers, but the reasons for which they moved from the north to the south may make them a unique population. For instance, Inuit in the north travel to Ottawa for tertiary health care (Kent, 2000). Therefore, this group of Inuit may experience more pre-existing health problems compared to other Inuit. In addition, some Inuit women in Ottawa left the north because of relationship problems. This may have a bearing on their health concerns, parenting, and family support.

Despite having documented urban Inuit family health and parenting, certain gaps in the literature remain. It was assumed that the expressed interest in childrearing of infants and toddlers is an indication of the focus on the well-being of young children. However, there are no formal reports or statistics on the health concerns of Inuit in Ottawa. It is imperative that future research document the health concerns, health status, and health care needs of this population. This information could then be used to develop future interventions and health promotion materials.

Implications for Research Methodology

This collection of studies relied on a participatory action research (PAR) approach to research with the Inuit community in Ottawa. Together, the academic and community research team members formed a partnership and working relationship which resulted in shared decision-making throughout the research process, from the development of research questions to the dissemination of findings. Community research team members disseminated research findings at international scientific conferences and academic team members made feedback presentations to the Inuit community in Ottawa. This illustrates our team's dedication to the partnership and our desire to enhance the capacity to conduct community-based research.

The full impact of this project on the community will only be revealed in the months and years to come. However, there is some indication from community participants that the PAR process has been successful.

As one community member stated:

It is nice to know that other cultures care. Like, all you guys <academic research team> are from different culture and it is nice to know that you care enough about our opinions, as our own culture.

Although a formal evaluation of the success of the participation action research approach has not yet been fully completed, community research team members have reported that there has been a significant increase in their involvement and decision-making during the project. Interviews with the community research team members completed at the end of the data collection phase suggest that changes have been detected even in the short term, included an increase in discussions about health. As one community research team member stated:

I think it is different now, because they are talking about health to anybody and everybody now, not just to their family not just their kids, not just to their particular family. And they, for Qapik <the Elder in the CD-Rom>, she's just realizing that she has to talk about the health itself to everybody, not just to, not just to the community, not just the family, but to everybody, you know. She's just realizing it.

This collection of studies also relied on a mixed methods approach. Focus groups were used in Study 1 and 2 and interviews were used in all three studies. Questionnaires were developed specifically for Study 2, and qualitative findings were presented in a quantitative manner for Study 3. Together, these uses of both qualitative and quantitative approaches substantially contributed to the knowledge on family health and parenting. The methods proved to be complimentary; for instance, the qualitative findings were useful for understanding the experience of using the CD-Rom. This research program is one of the first conducted with urban Inuit to rely on a mixed methods approach. The initial findings suggest that a mixed methods approach is an appropriate and useful approach to data collection. Further work is needed to understand which qualitative method (e.g., interview vs. focus group) might be most effective.

Conclusions

This research is innovative not only for its topic, but also for the process. This collection of studies sought to describe urban Inuit health information sources and dissemination strategies and parenting. Prior to this undertaking, there was a dearth of research on health information and parenting for urban Inuit. The research has evaluated a locally-tailored, culturally congruent health promotion tool. No other health promotion

tool has been developed specifically for urban Inuit, and none has ever been formally evaluated. The research program viewed health as family-centered and wholistic and recognized the importance of infants and children in the well-being of a community. In addition, an emic approach was used to characterize and understand the Inuit community in Ottawa. By seeking to understand the community on its own terms it was possible to capture the unique features of the community. The third study examined how an existing theoretical framework could be used to characterize community-specific parenting themes.

Finally, this project is one of the first, if not only, projects that has been conducted in partnership with an urban Inuit community organization. The use of participatory action research strengthened the community-specific focus and lent credibility to the findings (Smylie et al., 2006). The data collection and evaluation process was also community-grounded, as measures that were consistent with Inuit culture and respected preferences were developed. Community members and the community research team have expressed an interest in pursuing additional research projects, and this is taken as a sign of a successful partnership.

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APPENDICES

Appendix A

Source:

McShane, K. E. & Hastings, P. D. (2004). Culturally-sensitive approaches to research on child development and family practices in First Peoples communities. *First Peoples: Child and Family Review*, 1(1), 33-48.

Culturally-Sensitive Approaches to Research on
Child Development and Family Practices in First Peoples Communities

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Abstract

This paper focuses on highlighting some of the concerns that need to be addressed in conducting psychological research with First Peoples children and families. The extensive literature on healthy child development and family practices in Caucasian families is contrasted with the limited perspective on First Peoples families. We suggest that this is, in part, due to an unnecessary focus on problem behaviours of children from First Peoples communities. We contend that it is imperative for developmental psychologists to adopt a new perspective, by acknowledging the strengths and competencies of First Peoples families, and using more culturally-sensitive approaches to working with First Peoples.

In traditional psychological models of socialization, parents are given the primary responsibility for encouraging their children to adopt the values of society and facilitating their children's optimal social and emotional development (Grusec & Ungerer, 2003). A great deal of research has examined the familial influences on children's successful integration into broader social and academic spheres, but the vast majority of this research has been conducted by academics trained in Western scientific traditions and working with Anglophone Caucasian families. Recently, developmental psychologists have become increasingly interested in studying family relationships and children's development of competence in non-majority cultures, although little of this research has been done with families from Canada's First Peoples. The lack of research on the relations between parenting and children's competence in the First Peoples is not simply due to a lack of research on First Peoples families in general. Indeed there are many published studies, but this literature is disproportionately focused on children's development of *problems*. Perhaps this bias has been motivated by a legitimate concern and desire to help those children and families experiencing distress. Some First Peoples children and youth do have serious mental health problems, and obtaining access to appropriate services for those children is a serious issue. However, the reality is that, like children and youth in the majority culture, most children and youths from First Peoples communities *do not* have psychosocial problems that limit their abilities or competence (Gotoweic & Beiser, 1993; MacMillan, Welsh, Jamieson, Crawford, & Boyle, 2000). Why, then, have developmental psychologists overlooked this fact and failed to examine

the strengths of First Peoples families that support their children's competent development?

We contend that one reason why this knowledge gap has arisen is from ill-guided attempts to import the standard research procedures of Western social science disciplines, without regard for the cultural models and practices guiding communication and socialization in First Peoples communities. The lack of research on effective socialization in First Peoples families has contributed to an absence of information on the normative healthy development of First Peoples children. The success of Western-based approaches to treatment may be hampered by this limited understanding of cultural differences. By identifying positive and adaptive aspects of socialization, we will have a more accurate and complete understanding of the experiences of First Peoples families, and this information can be used to support the minority of First Peoples families in which children do have problems. Therefore, the goals of this paper are to instil readers with an awareness of culturally-sensitive approaches to research with First Peoples, and to underscore the importance of examining strengths of First Peoples families, instead of overlooking them.

Healthy Psychosocial Development: Effective Parenting for Positive Growth

Competence is generally used to describe children's healthy psychosocial development. Competence is demonstrated in a number of ways by children (Masten & Coatsworth, 1998; Saarni, 1999). Competent children feel good about themselves, adjust well to new situations and challenges, are typically happy, value their friendships and involvement with peers, and are successful in their scholastic endeavours. They express

their emotions and desires in socially acceptable ways, rather than becoming frustrated or confrontational. They are empathic and demonstrate good problem-solving skills with their peers, attempting to find prosocial solutions to disagreements rather than resorting to aggression.

Caregivers, and more specifically parents, have most often been identified as having the greatest influence of children's competent psychosocial development. The foundations of competent development are established in the caregiver's relationship with her or his infant (e.g., Maccoby & Martin, 1983). Effective parenting of infants is characterized as sensitive to the needs of infants and responsive to infants' cues (Weinfield, Sroufe, Egeland, & Carlson, 1999). In other words, these parents recognize what their infants' needs are, when their infants' require their care, and how to best provide this care to their infants (Ainsworth, Blehar, Waters, & Wall, 1978; Main & Solomon, 1990). This approach to infant care bestows infants with a secure attachment to their parents, such that infants feel safe, supported, and prepared to learn about the world.

Although secure attachment has been considered a cornerstone of the subsequent development of social and emotional competence, it is not sufficient, nor does it represent the sole contribution of parents. A variety of features of child-rearing of preschoolers, school-aged children and youth have been identified as supporting healthy psychological functioning. Some of the most frequently studied aspects of child-rearing include *limit-setting*: establishing rules and guidelines for children's behaviour; *modeling*: engaging in the kinds of behaviours parents want to encourage in their children; *reasoning*: explaining why rules are in place, behaviours are necessary, and what the consequences of children's actions are; *negotiating*: being flexible and allowing children to contribute to decisions;

showing warmth: being affectionate and caring; and *monitoring*: being aware of a child's where-abouts, activities, and friendships.

Parents who engage in limit-setting have children who engage in more prosocial behaviours with others (Cowan, Cowan, Schulz, & Heming, 1994) and perform better in school (Gray & Steinberg, 1999; Paulson, 1994). Parental limit-setting also is linked to lower aggression and delinquency (Denham, Workman, Cole, Weissbrod, Kendziora, & Zahn-Waxler, 2000), and anxiety and depression (Mattanah, 2001) in children. Parents who model caring and concerned behaviour toward others (e.g., are helpful and giving) have children who are more likely to react similarly when they see others in distress (Radke-Yarrow & Zahn-Waxler, 1984). Parents who use reasoning and negotiation when interacting and disciplining their children have children who demonstrate competent methods of self-expression (Kuczynski & Kochanska, 1990). Parental warmth is associated with greater prosocial behaviour and greater academic competence (MacDonald, 1992; Paulson, 1994). Parents who are effective at monitoring have children who are less antisocial, oppositional, and likely to use alcohol or drugs (Dishion & Patterson, 1997; Patterson, Reid, & Dishion, 1992).

Conversely, there are also a range of child-rearing behaviours that are considered less adaptive, as they are associated with undesirable outcomes in children and youth. For instance, a consistent finding across the literature is that parents' use of *corporal punishment*, including slapping, spanking, and more severe physical punishments, is associated with aggression, delinquency, depression, and other mental health problems (MacMillan et al., 1999; Strauss & Donnelley, 1994). Other aspects of child-care may become maladaptive if they are used inappropriately or excessively. For example,

although all parents need to shield their children from danger, parents who are *over-protective* and unnecessarily restrict their children's experiences tend to foster greater anxiety, shyness and dependence in their children (Barber & Harmon, 2002; McShane, 2003; Rubin, Burgess, & Hastings, 2002).

Of course, different parenting behaviours do not get used in isolation from each other. Children experience most of these kinds of child-care behaviours to varying degrees. Many researchers look at the pattern of parents' use of varying behaviours in order to characterize parents' general or overall styles of raising their children (Baumrind, 1971). These styles are often described as varying along two key underlying dimensions: *demandingness* and *responsiveness* (Maccoby & Martin, 1983). An *authoritative* style of child-rearing, which is both demanding (rules, limits, and expectations) and responsive (warmth, negotiation and reasoning) is typically associated with children's healthy psychosocial development and competence. This has been shown in children's higher self-esteem, social and moral maturity, caring and helpfulness toward others, involvement in school learning, academic achievement and educational attainment (e.g., Hastings, Zahn-Waxler, Robinson, Usher, & Bridges, 2000; Steinberg, Lamborn, Darling, Mounts, & Dornbusch, 1994). Conversely, children who have psychosocial problems or lower levels of competence most often are raised by parents who use non-authoritative styles of child-rearing. These styles include authoritarian (demanding but not responsive), permissive (responsive but not demanding), and neglectful or uninvolved (neither demanding nor responsive).

First Peoples Families: Limited Perspective on Psychosocial Development

The above detailed theories and research have been derived almost exclusively from Caucasian children and families. Furthermore, the majority of researchers examining children's competence and child-rearing practices are from a Western cultural background and have received their academic training from Western institutions. It is only recently that researchers have examined these research areas in non-Western cultures. Researchers have recognized that children develop within a complex system of relationships affected by numerous levels of the surrounding environment, one of which is the *cultural milieu* (Bronfenbrenner, 1979, 1989, 1993). Specifically, culture provides the broader context within which parents form their beliefs about which characteristics should be valued in children and how to promote those characteristics. Children also learn to interpret the meaning of parents' approaches to child-rearing according to the standards of their culture.

This acknowledgement of culture's role in socialization has spurred research examining features of child-rearing in different cultures. It has quickly become apparent that the patterns of associations between child-rearing practices and children's competence in Caucasian Canadian families (described above) are often different from those in non-majority culture families (e.g., Carson, Chowdhury, Perry, & Pati, 1999; Jambunathan & Counselman, 2002). For instance, studies examining Caucasian Canadian and Chinese families have found that parents' response to children's anxiety can have vastly different effects on children's competence. Chen, Hastings, Rubin, Chen, Cen, and Stewart (1998) found that in Caucasian families, parents feel negatively toward and are rejecting of, their children's anxious symptoms. This pattern is not seen in mainland Chinese families; these parents are more accepting of children's anxiety and feel better

about anxious children. Over time, Chinese children's anxious symptoms recede and social competence improves, whereas anxiety in Caucasian Canadian and American children tends to be more stable and associated with social difficulties (Chen, Li, Li, Li, & Liu, 2000). This suggests that although it might be possible to measure the same child-rearing characteristics across cultures, their relations to children's competence should not be assumed to be the same in different cultures.

In terms of First Peoples families, there has been limited work to date examining families and their role in healthy psychosocial development. It has been suggested that parenting values and attitudes of First Peoples are similar to those of Caucasian parents, although they differ in the degree to which these attitudes are translated into actual rearing of children (Glover, 2001). First Peoples and Caucasian parents hold many of the same values with respect to the psychosocial outcomes they seek to foster in their children. These include family connection, autonomy, friendships, maturity, cooperation, and responsibility. But there are also some differences in values. In the United States, traditional First Peoples values can include: generosity; respect for elders; respect for all creation; harmony, and non-interference (Deyhle & LaCompte, 1999; Glover, 2001; Kallam & Coser, 1994). First Peoples also differ in how they try to promote these healthy outcomes. Research with First Peoples in the United States has found that these families rely heavily on modelling and storytelling as vehicles of teaching or socialization (Deyhle & LaCompte, 1999; Glover, 2001; Kallam & Coser, 1994). In response to children's misbehaviours, common discipline strategies include power assertion, love withdrawal, inductive discipline, shame or embarrassment (Hoffman, 1977). A feature that appears to be unique to First Peoples is the dispensing of punishment by family members other than

parents: such as aunts, uncles or grandparents. The goal of this involvement of other family members in disciplinary actions is to protect the bond of love between parents and children, and also to reinforce the extended family's involvement in the child's day-to-day upbringing (LaFromboise & Low, 1998).

One of the most striking differences in general parenting approaches between First Peoples and Caucasian parents is best described below:

The dominant culture often shows concern about the relative freedom given to a Native American child and the apparent lack of parental concern about the child's behavior. What appears as *excessive permissiveness* or *indulgence*, however, may consist of allowing children to develop in a *healthy way*. Autonomy is highly valued, and children are allowed to make their own decisions and operate semi-independently at an early age with the freedom to experience natural consequences. (italics added; p. 218; Glover, 2001).

Supporting competent development is the specific goal underlying this technique. Parents and researchers from outside First Peoples communities may not see this technique as supporting that goal, but this difference in perspective reinforces the overarching role culture plays in establishing the meaning and effects of parental actions. Some research has examined the links between child-rearing attitudes and practices, and children's competence in First Peoples families. The larger extended family, increased time spent with tribal elders, and increased frequency of activities involving the entire family have been associated with a decreased likelihood of Ojibway adolescents being involved in delinquent activities (Zitzow, 1990). First Peoples children who are raised in a warm, accepting, nurturing environment exhibit more positive social skills (Rohner,

Chaille, & Rohner, 1980), similar to what has been observed with Caucasian families. The emphasis on self-reliance and autonomy by American Indian parents seems to promote an early emergence of developmental milestones; including dressing oneself, and doing regular chores (Miller, 1979, as cited in Joe & Malach, 1992). Caucasian children are reared in a *child-centered* world, where parents expect them to accomplish tasks appropriate for their age. This contrasts with American Indian children who are reared in an adult-centered world, where they are encouraged to master adult tasks (e.g., responsibility for self-care).

Another interesting link between the emphasis on autonomy and children's competence comes from an unlikely place: parents' views of special needs children. Connors and Donnellan (1998) conducted a research study to examine Navajo views on disabled children. This information was gathered during an anthropological research study that was conducted at a residential facility for exceptional First Peoples children on the Navajo Nation, in the United States. This research was approached from a *participant-observer* perspective, whereby the researchers fully immersed themselves in the Navajo culture to the greatest extent possible in order to understand and document the culture's unique values and social processes about disabled children. The families selected for this research included at least one child who was labelled as autistic or mentally retarded by Western psychologists, and who was in residence at the facility. Connors and Donnellan (1998) noted that:

A great deal of permissiveness is given to Navajo children until the age of six or seven and this pervasive cultural child-rearing practice helps to explain the

tolerance accorded to the clients with autism and those behaviors that are perceived to approximate notions of social competence. (p. 175)

The authors go on to state that this notion of 'permissiveness' applies to physically handicapped children as well. These children are considered children, not in a helpless sense, but rather in a 'becoming persons' sense. This tolerance for and acceptance of individuality also makes Navajos less inclined to identify behaviours as 'problems' and more likely to view them 'characteristics' (Connors & Donnellan, 1998). Although no research exists on how these views influence parenting practices, it is known that Navajo parents are reluctant to segregate or isolate children with disabilities. It is also known that this acceptance fosters a more relaxed attitude toward the role of the disabled child in the Navajo family structure. Thus, it is conceivable that this greater integration leads to more natural and healthy development in those children. Connors and Donnellan (1998) conclude that "this suggests that the traditional Navajo culture provides flexibility and resiliency in the face of disability that makes mental and emotional adjustments somewhat easier for the families to bear" (p. 179).

Clearly, this small collection of studies supports the proposition that effective and adaptive socialization practices of the First Peoples promote competence and healthy psychosocial development in their children. Both the value system of the First Peoples culture, and the child-rearing attitudes and behaviours of parents and extended family members, may confer advantages to children of the First Peoples. However, it is equally apparent that there is a dearth of empirical investigations on the links between socialization and competent development in the First Peoples. The more extensive

literature on psychosocial problems needs to be balanced by more studies of typical, normative, healthy family functioning and child development.

In the remainder of this paper, we make several suggestions for ways in which developmental psychologists can begin to redress past oversights. These include the adoption of a different theoretical model or framework, the utilization of more sensitive, culturally-appropriate methodologies for learning about socialization and development in First Peoples, and novel approaches to initiating and pursuing the research process.

Resilience: Focusing on the Positives

Thirty years ago, a few leading developmental scientists began to draw researchers' and clinicians' attention to the fact that many, perhaps most, children raised in circumstances of hardship and adversity do not develop psychological problems or psychiatric disorders (e.g., Garmezy, 1974, Rutter, 1979). Despite experiencing economic deprivation, homelessness, social discrimination or other risks and disadvantages, these individuals develop well, attaining competence and health, and accomplishing relevant developmental social, academic, and occupational milestones. The prevalence of *resilience*, attaining healthy developmental outcomes despite the experience of adversity, points to the adaptability and tenacity of humans, and highlights the truism that problems are the exception, rather than the rule, of development. Researchers' investigations into the factors that predict or support resilience have revealed that resilient children are not extraordinary; they are ordinary (Masten, 2001). If children have intact neurocognitive functioning (e.g., no evidence of neurological injury)

and supportive, involved parents, they are likely to survive even seriously adverse circumstances without being scarred.

Most of the research on resilience has been conducted with lower-income, visible minority groups in the United States. It is important to note, however, that epidemiological studies of the First Peoples indicate that healthy psychosocial development is the norm in these communities as well (e.g., Gotowiec & Beiser, 1993; MacMillan et al., 2000). Given the low average annual income of Canada's First Peoples families, the number of First Peoples families living in sub-standard housing, the number of First Peoples communities located in remote locales with limited access to services, and the enduring prejudices held toward First Peoples by many in Canada's majority culture (Joe & Malach, 1992; Strauss, 1995), it would be reasonable to state many of the children of the First Peoples are being raised under conditions of risk. Thus, the fact that most of these children do not show evidence of marked psychosocial difficulties is evidence that, like children from other communities, *they are resilient*.

Given the salient contributions of effective parenting to the resilient development of children in other cultural groups, it is likely that some of the qualities of parenting by First Peoples (e.g., modelling, involvement of other family and community members, maturity demands) protect children from the negative effects of adversity and hardship, and promote their healthy psychosocial development. By refocusing our theoretical perspective from models of illness and pathology (the effects of risk factors on the development of problems), to models of health and competence (the contributions of protective factors to the development of positive outcomes), developmental scientists can support effective parenting and resilient development in the First Peoples. Further, by

accurately characterizing the ways in which First Peoples children show their competence, and identifying the family and cultural features that support this competence, we may be able to design new and culturally-meaningful ways to assist the minority of First Peoples families in which children are not manifesting resilience. Cooperative and proactive recommendations for child-rearing (“Try this; it has worked for your neighbours.”) are likely to be more effective for helping families to overcome their troubles than prohibitive directions drawn from dissimilar experiences (“Don’t do that because we’ve found it doesn’t work.”).

New Directions for our Understanding of First Peoples

We are now faced with the challenge of shifting our research focus with First Peoples families away from a negative-outcome focus, to a competence and resilience focus. This shift will permeate through all levels of research, including *topic*, *participants*, *measures*, and *process*. Traditionally, most researchers have taken an epidemiological approach whereby groups of First Peoples are described on a broad variety of characteristics (e.g., age, gender, level of schooling, psychiatric problems), but any given characteristic is not examined in great depth. This has applied equally to examinations of children’s problems and parents’ socialization of children. Therefore, as well as refocusing attention from problems and limitations to competencies and strengths, researchers need to shift from broadly but shallowly surveying the First Peoples to obtaining more detailed, in-depth accounts of their experiences.

In most cultures parents are the primary caregivers. However, in First Peoples families the extended family plays a large role in raising children (Joe & Malach, 1992;

MacPhee, Fritz, & Miller-Heyl, 1996). Kinship, emphasizing the inter-connectedness of many family members and even non-familial community members, is one of the fundamental traditional values of First Peoples. In addition to biological parents, the socialization of children involves grandparents, other family members, and tribal elders (Burgess, 1980; Cooke-Dallin, Rosborough, & Underwood, 2000; LaFromboise & Low, 1998). In fact, compared with Canadian Caucasian families, grandparents and extended families are more involved in First Peoples families and more First Peoples children live in homes with three or more generations of family members (Thompson, 2003). The family constellations of the First Peoples can also differ in other ways. For instance, infants may be reared in a separate home by grandparents or uncles and aunts. As youths they may continue to live with other family members, who can include third or even fifth-degree relatives (MacPhee et al., 1996; Seidman et al., 1994). A ‘family’ does not only consist of children with their biological parents, but includes all community members involved in socialization of children. Thus, in terms of research *participants*, we will need to broaden our definition of parents to include all individuals involved in child-rearing. With respect to the research *process*, this means that we should *ask* who the members of a ‘family’ are (family and nonblood relatives) and avoid assuming that only the biological parents comprise the family. Conversely, we also should not assume that *all* members of the extended family should be included. In our attempts to understand familial influences on First Peoples children’s development and competence, we need to resist applying Western traditional notions of ‘parents’ and look for more culturally appropriate definitions of parents.

The existing research on parenting among First Peoples parents has relied on traditional social science methods of inquiry, including questionnaires with rating scales. Some researchers have questioned the appropriateness of these methods (e.g., Beiser, 1981). As these questionnaires were principally developed for use with Western cultural groups in North America, they may not be valid or appropriate for use with other cultural groups including First Peoples. The content covered in those questionnaires may not be relevant for the experiences of First Peoples. The wording of questions may contain implicit biases, be unclear, or be unfamiliar to First Peoples. The concepts of ratings scales and anchor terms (e.g., *strongly disagree*) have grown out of Western academics' work and may not be typical of First Peoples' thoughts and perspectives on child rearing and children's competence. Also, methods of interpreting the meaning of scores usually have been standardized on the basis of Caucasian groups who differ immensely from most First Peoples groups on a number of characteristics, thus potentially rendering all comparisons or inferences about test results inaccurate and invalid.

One might infer from this critique that researchers simply need to standardize test scores with First Peoples groups in order to use these existing questionnaires more appropriately. While that certainly would be helpful, we contend that new approaches and methods will also need to be researched. Traditional social science questionnaires should be supplemented (if not replaced) by other information gathering methods that are adapted to better match traditional First Peoples customs and values. Although common in some social science fields, *narrative approaches* have only recently been recognized as potentially valuable and rich sources of information by socialization researchers working within psychology. Narrative approaches allow parents to generate open-ended

and self-directed accounts of their parenting practices; this may be an ideal method because First Peoples culture stresses the importance of conversation (e.g., Carbaugh, 2001). Participants' freely generated accounts of their beliefs, experiences and practices can be examined for themes and content that are directly relevant for First Peoples socialization of children. Similarly, narrative reports from parents, other family members, teachers or even children themselves may be more effective ways of identifying First Peoples children's competent development. The flexibility of narrative procedures makes them well-suited for application to a range of topics.

One last area that will require a shift in focus is the process through which research is initiated and maintained. Standard research has been likened to a 'helicopter' process, where the researcher drops in for a quick data collection trip and is never seen again. Montour (1987, as cited in Macaulay et al., 2003) described this experience as "outside research teams swooped down from the skies, swarmed all over town, asked nose questions that were none of their business and then disappeared never to be heard again". This kind of researcher-initiated approach often benefits the researcher and his or her academic career, but is of little or no benefit to the First Peoples communities. Darou and his colleagues (Darou, Hum, & Kurtness, 1993; Darou, Kurtness, & Hum, 2000) describe the James Bay Cree of Québec as having endured countless negative experiences with non-Aboriginal researchers. As a result, they have ejected all but one researcher and put a moratorium on all future research in their territory. They state that this is due to the researchers' refusal to accept Cree authority, and the *little perceived benefit* of this research for the community. Darou, Hum, and Kurtness (2000) concluded with the following suggestions: (1) "It is entirely inappropriate to conduct research *unless you*

have been invited in and you have a clear and relevant purpose” and (2) “It is important that your research put something valuable back into the community” (italics added; p. 52). Overall, the process of research needs to be collaborative in nature and yield some tangible outcomes that can be of benefit to the community.

Culturally-Sensitive Directions for Research

Theories regarding cultural differences in psychopathology have centered around two opposing perspectives: emic vs. etic (Dragnus & Tanaka-Matsumi, 2003). The *emic* approach focuses on the culture-specific behaviour, customs, values and traditions of a specific culture group. This position has also been described as a *relativist* perspective. From this vantage point, researchers focus on the scope of cultural variation, the need to understand the unique phenomena within any given culture, and to study cultural groups on their own terms. This perspective is contrasted with an *etic* or *universalist* perspective which looks for universals that are ‘true’ across cultures and focuses on the differences in levels of certain dimensions and categories across different cultural groups.

For culturally-sensitive research to be conducted with First Peoples families, an emic approach needs to be taken. Researchers must clearly understand the culture before embarking on a research project. Douglas (1994) presented an account of her experiences in understanding schooling within an Inuit community as a first step towards recontextualizing the institution of schooling to better reflect the community context. Likewise, Gillis (1992) sought to understand First Peoples parents’ views about early childhood education prior to suggesting changes to day care curriculum. These two researchers were successfully able to understand First Peoples communities prior to

suggesting changes to schooling, and circumvented the use of false assumptions of First Peoples to guide their research.

A corollary point is the need to respect the heterogeneity of First Peoples. Often First Peoples are considered a homogenous group and their culture is reduced to a single entity (Gross, 1998; cited in Coleman, Unrau, & Manyfingers, 2001). Recognizing that there are intergroup differences should not be made at the expense of recognition of intragroup differences. With over 550 recognized Native nations in the United States and over 1000 reserves in Canada, there exists considerable heterogeneity (Thomason, 1991; Weaver, 1997, 1999). Additionally, being part of a culture does not mean that all individuals subscribe to the specific values and traditions of that culture to the same degree. As Gross (1998; as cited in Coleman et al., 2001) stated “all the study in the world about a given culture or subculture might not lend a hint of explanation of the behavior or attitudes of a single member of that culture or subculture” (p. 9).

Understanding First Peoples at an individual, family and community level is a requisite of any research endeavours that hope to be insightful, accurate and useful.

Working with a community is perhaps the most culturally-sensitive approach to research with First Peoples populations. In this framework for conducting research, communities are involved in an equal partnership with researcher. This method is called *participatory action research* (PAR) and is defined as the systematic enquiry, involving collaboration of those affected by the issue being studied and the researchers, for the purpose of education and taking action or effecting social change (Green et al., 1995). PAR is based on the integration of community members as equal partners; integration of the intervention and evaluation the intervention’s success; and creation of learning

experiences for the program's researchers and staff, as well as participants. A unique feature of this research perspective is the equal involvement of 3 members: (i) community researchers; (ii) academic researchers; and (iii) the community advisory board (community members). The importance of the PAR process cannot be overstated, as both research outcomes and practical knowledge transfer will contribute to First Peoples' acquisition of the information, skills and tools needed to continue advancing their own welfare.

An excellent example of the successful implementation of this research agenda in a First Peoples community in Canada is the Kahnawake Schools Diabetes Prevention Project (KSDPP; Potvin, Cargo, McComber, Delormier, & Macaulay, 2003). Members of the Kahnawake community recognized increasing rates of diabetes as an important health concern. KSDPP was therefore founded by Kahnawake community members, working with researchers, with the goal of reducing the incidence of Type 2 diabetes amongst the First Peoples in Kahnawake. KSDPP seeks to accomplish this by implementing intervention activities for schools, families and the community that promote healthy eating, physical activity and positive attitudes about health. They conduct community-based research on these activities and report all research results back to the community. They also train community intervention workers, and academic and community researchers and individuals from other First Peoples communities to promote capacity building. Of particular significance is the adaptation of the curriculum to coincide with the values and beliefs of the Mohawk culture. This impressively demonstrates a thorough understanding of the culture, providing evidence for a successful emic approach.

Ethical Considerations with First Peoples

With the shift toward PAR, recognizing and promoting active community participation in research is replacing past research models in which researchers held exclusive control over the process and the results (Macaulay et al., 1998). Thus, it will be essential to advance a code of research ethics that focuses greatly on confidentiality, avoidance of harm and potential benefits *at a community level*. It is worthy to note that, correspondingly, Canadian codes of ethics (e.g., MRC, NSERC, & SSHRC, 1998) and those of First Peoples groups (e.g., Inuit Tapirisat of Canada and Nunavut Research Institute, 1998) have grown to reflect this sharing of leadership, research design, and decision-making (Macaulay et al., 1998).

Additionally, integral to PAR is the development of a code of ethics to guide each specific research study, developed through the collaboration of the researchers and the community members. Macaulay et al. (1998) provide a useful example of the successful development of a code of research ethics applied to the KSDDP. Their code included a policy statement about the incorporation of a Mohawk perspective into the project, clarification of the roles and obligations of the partners, and guidelines for control of data and dissemination of results. Thus, through the process of discussion and negotiation that is essential to a true partnership, the expectations, rights and responsibilities of all research collaborators were clearly and openly established.

Researchers and practitioners must also be aware of ethics on a daily level, through the ethics of personal interaction (e.g., Ellerby, McKenzie, McKay, Gariépy, & Kaufert, 2000). Respect for the rights, and protection of the well being, of participants in research must be informed by an awareness of and sensitivity to the values and traditions

of the culture in which participants live. Brant (1990) described how potential interpersonal conflicts can be avoided by utilizing First Peoples' practices of non-interference, non-competitiveness, emotional restraint, and sharing. Non-interference is rooted in maintaining deep respect for every individual's independence, such that approaching an interaction as an instructor, or attempting to persuade or coerce another person, are undesirable ways to behave. Non-competitiveness serves to minimize group rivalry, and prevents the embarrassment that a less able group member might feel in a situation that has the potential to reveal individual differences in ability. Emotional restraint promotes self-control and discourages the expression of strong emotional reactions, either positive or negative. Sharing is based on generosity and the avoidance of hoarding of goods or resources. Together, these practices emphasise respect and egalitarianism in interpersonal interactions. Researchers' use of these practices to discuss the research procedures and process, and negotiate the code of research ethics, should serve to facilitate successful and mutually beneficial interactions with the First Peoples children, families and communities involved in investigations.

Concluding Remarks

A great deal is known about Caucasian children's healthy psychosocial development and the qualities of parenting that support their competence. Conversely, developmental scientists working with First Peoples cultures have concentrated their efforts on children's problems and families' difficulties. This has contributed to an incomplete and unrepresentative picture of First Peoples families. Researchers should approach First Peoples communities with the goal of understanding the culture, by taking

an *emic* approach. This process should be done by developing meaningful relationships between academics, researchers, and community members before proceeding with research, and maintaining this collaboration through all stages of the research process. The majority of children in First Peoples communities *are* healthy and competent and do *not* have psychological problems. Redirecting our research efforts towards focusing upon the strengths of families and children, and using procedures that are appropriate and sensitive to the values and traditions of the First Peoples, will be essential for obtaining a more balanced and accurate understanding of socialization and development within these communities.

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Appendix B

Text of message 1: What you need to know about pregnancy

Now that I know that you have a husband and you will be getting pregnancy soon. I want to tell you what you will have to be doing once you get pregnant. You will have to find out how many months along you are or you will have not find out how long you haven't had your period, and you would have to tell me this is how many months I haven't had my period now. Once a mother finds out that one is pregnant she would say "maybe the baby is forming from the eyes already." They say that because they believe the babies start forming from the eyes first. They say any kind of babies forming regardless if it is an animal or human, it is believed the baby starts forming from the eyes first that is why one would say "There might be a baby forming from the eyes in you tummy now". You will have to become active you cannot just sit around and not do anything. Being inactive can also create problems for your pregnancy, for one thing, if you are inactive the placenta can get stuck to the uterus if you are active and once you know you will cannot miscarry anymore. We would now from the size of you pregnancy and if the size goes to your bellybutton then we would now you are not likely to have a miscarriage anymore once the three months period is over and goes to the forth months that is when we determine that you would not miscarry.

Appendix C

Text of message 2: Supporting mothers during pregnancy

The reason why we had to be advised when we got pregnant for the first time is because we had to prepare for the future and for our body. My body when I am pregnant I am supposed to be free of pain mentally because I have too much to worry about. That is why we had to follow what is told to us so I will prevent my body from getting any kind of sickness for the duration of my pregnancy. Try not to tell me anything that is too hard to take in and if I say anything hurtful someone can also say something that would be hurtful for me. It is told that during my pregnancy I would have to live a good life so that I will prepare for the future of giving birth. To give birth you will be so close to death to deliver the child. My body as a mother will have to be properly prepared for anything that might be mentally straining and that might be mentally too hard for you and not add on that will give you mental pain. So that you will be mentally healthy and be healthy to have a safe passage for the unborn child. It is said when a person is pregnant and ready to give birth you have to come close to death that is why we were told to be prepared so we will be healthy the mother and the unborn child to be free of mental pain. So the unborn child will be born healthy. Those were the first things that we were told. We were told not to cause problem to another person. And not instigate a problem first toward another person. Both the parents whether it is the father or the mother are the same, because the person can easily be taken away by death. A father can easily have the fate of death when he is out hunting or out on the land. A mother can easily be die when she is giving birth. That is why you have to make sure you know what you are doing in your life and be try to be healthy.

Appendix D

Interview Questions: Assessment of Expectations of the CD-Rom (*Pre*)

Tell me what you think it will be like to use the CD-Rom.

Do you think you will be able to use the information from the CD-Rom?

Appendix E

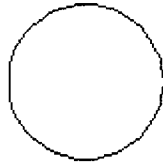
Questionnaire: Assessment of Expectations of the CD-Rom (*Pre*)

1 Are you looking forward to seeing the CR-ROM?

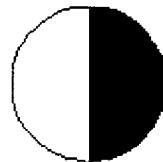
no

yes

2 Would you recommend the CD-Rom to someone?



No

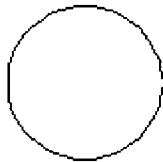


maybe

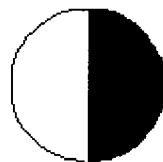


yes

3 Do you think you'll learn something from the CD-Rom?



No

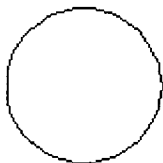


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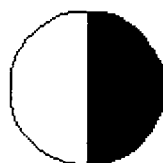
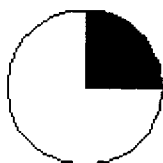


yes

4 Would you share the information with someone?



No

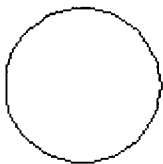


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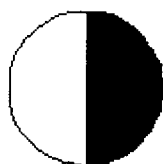


yes

5 Do you think the message will make sense to you?



No

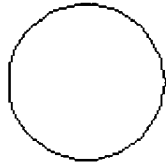


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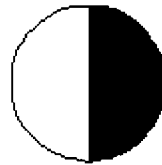
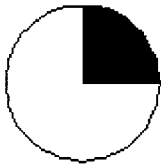


yes

6 Will the message be helpful for you and your family?



No

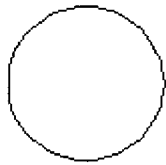


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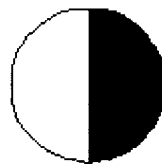
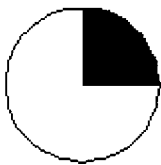


yes

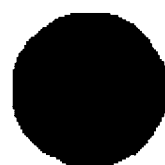
7 Do you think the Inuit-specific information will be useful?



No

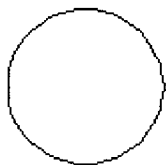


maybe

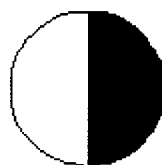
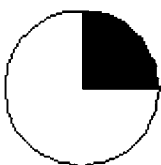


yes

8 Will it be good that the information comes from an Elder?



No

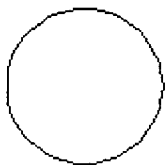


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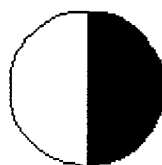
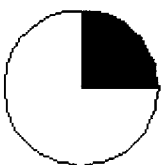


yes

9 Will it be good that the information comes from Inuit?



No

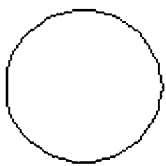


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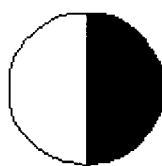
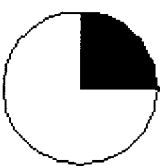


yes

10 Will it be helpful to have the community facilitator show you the CD-Rom?



No

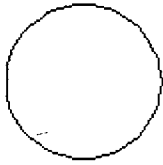


maybe

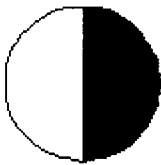
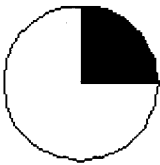


yes

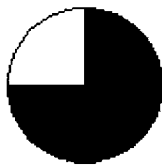
11 Will the CD-Rom be like talking to someone?



No

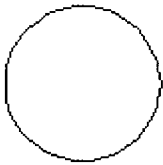


maybe

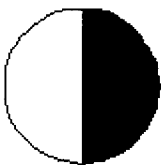
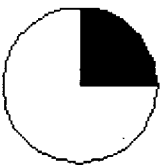


yes

12 Will the CD-Rom be like reading a brochure?



No



maybe



yes

Appendix F

Interview Questions: Assessment of Reactions to the CD-Rom (*Post*)

Tell me what it was like to use the CD-Rom.

Can you think of ways you would use the information that the Elder gave you?

How was the CD-Rom different than what you expected?

What did you like the most about the CD-Rom?

What did you like the least about the CD-Rom?

Appendix G

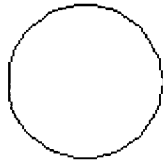
Questionnaire: Assessment of Reactions to the CD-Rom (*Post*)

1 Did you like the CD-Rom?

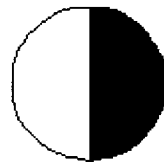
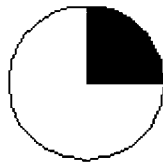
No

yes

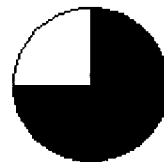
2 Will you recommend the CD-Rom to someone?



No

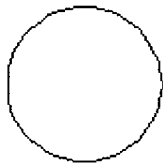


maybe

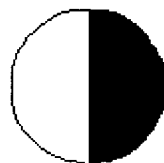


yes

3 Did you learn something from the CD-Rom?



No

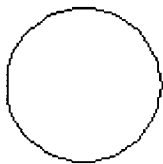


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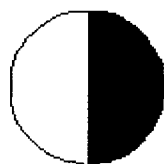


yes

4 Will you share the information with someone?



No

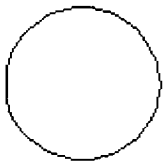


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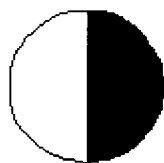
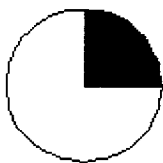


yes

5 Did the message make sense to you?



No

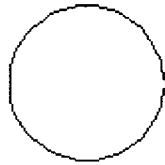


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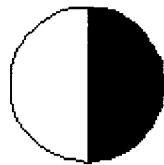
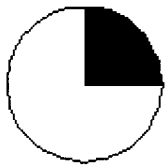


yes

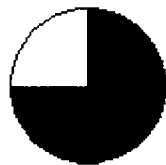
6 Will the message be helpful for you and your family?



No

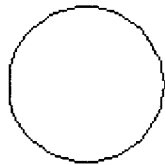


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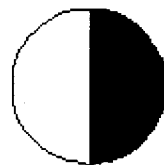
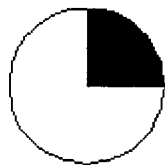


yes

7 Was the Inuit-specific information useful?



No

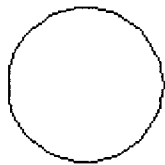


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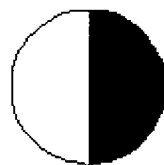
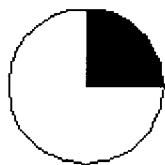


yes

8 Was it good that the information came from an Elder?



No

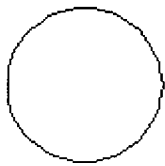


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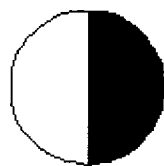


yes

9 Was it good that the information came from an Inuk?



No

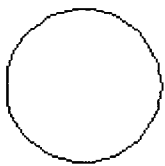


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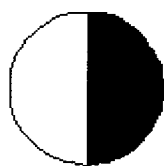


yes

10 Was it helpful to have the community facilitator show you the CD-Rom?



No

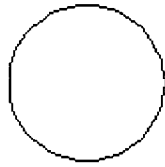


maybe

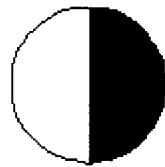
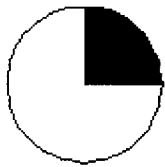


yes

11 Was the CD-Rom like talking to someone?



No

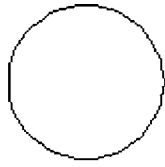


maybe

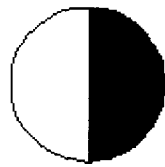
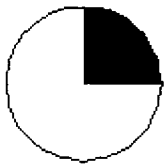


yes

12 Was the CD-Rom like reading a brochure?



No



maybe



yes

Appendix H

Focus Group Items: Assessment of Reactions to the CD-Rom (*Follow-up*)

1. Which feature(s) was/were best about the CD-Rom?

Elder

Someone talking

Something to look at

Community facilitator

Inuit person

Inuit-specific message

In Inuktitut

2. What would you change about the CD-Rom?

3. How does the CD-Rom compare to other ways of sharing health information?

Appendix I

Coding scheme for questions assessing expectations of the CD-Rom

Code	Description
Interest	<ul style="list-style-type: none">-Positive intent to use information or they are likely or hoping to use the information.-Positive intent in using the CD-Rom-Requesting a copy of the CD-Rom-Expressed interest topic, Inuit-specific content, technology or novelty.
Concern	<ul style="list-style-type: none">-General uncertainty-Concern about technology (ability to use computer, use of navigation).Concern about content (language, ability to understand message and content)
Contingent	<ul style="list-style-type: none">-Expressing interest in using the CD-Rom and the information if a certain criterion or condition is metCriteria/Conditions include:<ul style="list-style-type: none">-ease of technology-clarity of content-message is culturally-appropriate (i.e., in terms of language, culture, or Elder)

Appendix J

Coding Scheme for Parenting Themes

Code	Description
Affection and Love Behaviours	<p>-parent reports that parenting is rewarding, a joy, indicates he/she enjoys watching children grow</p> <p>-support parents offer, actions they do, things parents say, supporting financially, etc.</p> <p>(e.g., I support her, I talk to her, I help with homework)</p> <p>-Note: If parents mentions a child characteristic, and then mentions how she/he supports this, This goes under “Respect for Individuality”).</p> <p>-Note: Parents must say something more than “I support them”, or “I work” or “I am employed”, “everything”. Although, “I support them financially” would count as it is specific enough and focuses on what is offered to the child, as opposed to what the parent does (i.e., is different than “I work”).</p>
Beliefs	<p>-sense of responsibility, hard, challenging, etc.</p> <p>-statements about how child is center of the parents’ lives, how influential child is.</p> <p>**If parents says: “It’s hard especially when they don’t want to eat” This goes under ‘Concern for Child’s Health’.</p>
Child Age Differences	-Parent makes mention of the fact that there are differences between children and adolescents
Child Characteristics	-comments about identity, personality, characteristics, abilities, skills, temperament
Concern for Child’s Health	<p>-parent reports difficulty in ensuring child’s health.</p> <p>(Eg., It’s difficult, especially when they don’t want to eat; Keep them in healthy shape)</p>
Contextual Stressors	-unpredictable, chaos, economic/financial stresses, work stresses, social context, CAS threats/occurrence, child in care (not living with parent)
Family and Community	<p>-parent discusses the help and/or involvement of family members or community organizations</p> <p>-could include simply having indicated they accessed them (E.g., also to have parenting classes here at the resource centre really helped)</p> <p>-Parent must state that s/he accesses these resource himself/herself; not simple that they exist.</p> <p>-Does NOT include examples of husband helping at home.</p>
Future	<p>-parent discusses child’s future, plans, ideas</p> <p>(E.g., ‘Making a better future for them’)</p>
Grandparent vs. Parent Differences	-Includes parents mentioning differences with grandchildren and children; that they prefer being a grandparent or parent, etc.

Negative Emotions	-general frustration, anxiety, anger (e.g., It's frustrating, stressful)
Responsive and Respectful	-parent responding to their child's needs or abilities -parent must first indicate a child's characteristic, and then say what they do/offer/say as a consequence of the child's ability/emotion/situation/preference/etc. (E.g., he's very active, so we enrolled in soccer; when she's sad, I talk to her, when she's happy, I support her)

Appendix K

Coding Scheme for Subcategories of Parenting Themes

Major Category	Sub category description and example
Child characteristics	<p>Independent/Strong: E.g., <i>unique, different, own personality, strong</i></p> <p>Intelligent/Skilled/Competent E.g., <i>smart, can do it, big vocabulary</i></p> <p>Nurturant/Considerate E.g., <i>affectionate, loving, willingness to help</i></p> <p>Happy E.g., <i>cheerful, sunny</i></p> <p>Negative E.g., <i>stubborn</i></p> <p>Other E.g., <i>innocent, relaxed, beautiful, enjoys Inuk culture, humorous</i></p>
Behaviours	<p>Warmth/Supportive: Attempts to comfort, support, reassure children/grandchildren, including physical affection. E.g., <i>I care for them</i></p> <p>Instruct/Teach/Guide/Talk: Attempts to teach children about life lessons or specific activities or skills. Includes communication with child. E.g., <i>Teach them to help others so they won't be selfish</i></p> <p>Basic needs (food, home, clothing, etc.): Provision of basic needs for the children. E.g., <i>I support them financially</i></p> <p>Control/Discipline: Attempts to control or discipline child. E.g., <i>I try to discipline them as much as I can.</i></p> <p>Other E.g., <i>prayers, using language to promote culture, fostering a sense of family membership, providing choices.</i></p>
Beliefs	<p>Responsibility/Challenge: Acknowledgement of difficulty of being a parent. E.g., <i>It's a lot of work</i></p> <p>Relationship-focused: Expressing the impact of the parent-child relationship, or of the role as a parent. Describing the influence that such an experience has had on them. E.g., <i>Without them my life would be empty</i></p> <p>Competence: A sense of mastery or accomplishment in their role as a parent. E.g., <i>I know I did any amazing job</i></p> <p>Other <i>Keeps me out of trouble</i></p>

Appendix L

Relatedness and Autonomy Coding Scheme for Classification of Parenting Themes

Category	Description
Relatedness	Focused on the well-being of family or community. Linked to love, attachment, caring, support (e.g., emotional), loyalty, and fostering a sense of belongingness. E.g., <i>I fear they are losing their culture.</i>
Autonomy	Focused on personal choice, self-agency, independence, personal rights, and other individual pursuits (e.g., education). E.g., <i>I give them lots of choices.</i>
Other	Focused on neither family nor autonomy. E.g., <i>Parenting keeps me busy.</i>

Appendix M

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