

Journal of Transcultural Nursing

<http://tcn.sagepub.com>

Literature Summary of Some Navajo Child Health Beliefs and Rearing Practices within a Transcultural Nursing Framework

Suzanne Phillips and Sandra L. Lobar

J Transcult Nurs 1990; 1; 13

DOI: 10.1177/104365969000100203

The online version of this article can be found at:

<http://tcn.sagepub.com>

Published by:



<http://www.sagepublications.com>

On behalf of:

Transcultural Nursing Society

Additional services and information for *Journal of Transcultural Nursing* can be found at:

Email Alerts: <http://tcn.sagepub.com/cgi/alerts>

Subscriptions: <http://tcn.sagepub.com/subscriptions>

Reprints: <http://www.sagepub.com/journalsReprints.nav>

Permissions: <http://www.sagepub.com/journalsPermissions.nav>

Citations <http://tcn.sagepub.com/cgi/content/refs/1/2/13>

LITERATURE SUMMARY OF SOME NAVAJO CHILD HEALTH BELIEFS AND REARING PRACTICES WITHIN A TRANSCULTURAL NURSING FRAMEWORK

SUZANNE PHILLIPS, M.S.N., R.N.*
AND SANDRA L. LOBAR, M.S.N., R.N.‡

Leininger (1978) defines transcultural nursing as a “subfield of nursing which focuses upon a comparative study and analysis of different cultures and subcultures in the world with respect to their caring behavior; nursing care; and health-illness values, beliefs, and patterns of behavior with the goal of developing a scientific and humanistic body of knowledge in order to provide culture-specific and culture-universal nursing care practices” (p. 8). One goal of transcultural nurses is, according to Leininger (1978), to “identify, test and understand a body of transcultural nursing knowledge and practices” (p. 8). Nonnative American nurses who work with a native American population, such as the Navajo Indian tribe, are frequently unaware of the significance of beliefs and traditions within everyday life practices. Since childbearing and childrearing are important life events in the Navajo society, tribal beliefs, traditions, and practices impact on parenting. Nonnative American nurses’ ignorance of the Navajo view of their world can lead to misunderstandings and frustrations on both sides. Therefore, a nurse’s ability to acknowledge and to sustain Navajo “caring” within their cultural context facilitates successful interactions between Navajo families and the health care system. A thorough review of the literature establishes a parameter which can be used as a basis for further assessment of the family’s belief system.

The Navajo are the largest of the American Indian tribes with an estimated population in 1986 at over 171,000 (U. S. Department of Health & Human Services, 1986). Most of the population resides on the 25,000 square mile reservation which lies within the

states of Arizona, New Mexico, and Utah. The reservation is an area of semi-arid desert, mesas, and canyons on the southern portion of a plateau which has elevation ranges of 3,000 to 10,000 feet. Climate is temperate in summer and cold in winter with wide day-night temperature variations. Families are widely scattered throughout the reservation. Many Navajo still live in small cabins or in the traditional hogan—a one-room, windowless, mud and log hut—several miles from their nearest neighbors. Water may need to be hauled long distances. Larger groups have settled around old missions, government stations, and tribal headquarters (Down, 1972). An increasing number of Navajo are now living and working in cities and towns near or within the reservation. Because of their isolation, the Navajo have retained much of their traditional culture and language. Even so, the social structure of the tribe is changing. Shepherding is still a major form of livelihood, but it is rapidly giving way to industrial development and tourism. The pick-up truck has replaced the horse-drawn wagon as the chief means of transportation. Traveling long distances from home is still difficult because of washed-out or sand-covered dirt roads (Chisholm, 1983).

Caring Behaviors

Caring, according to Leininger (1988) refers to “actions directed toward assisting, supporting, or enabling another individual (or group) with evident or anticipated needs to ameliorate or improve a human condition or lifeway” (p. 156). Navajo society has undergone changes and adaptations over the years. Many traditional beliefs about child care are no longer practiced or only partially practiced by the younger Navajo population. Boyle and Andrews (1989) note that cultural norms within a group can conflict with one another and behavior is not always clear. Choice is a major factor. Personal forces such as temperament, education, experience, maturity, and motivation influence participation. The culturally sensitive pediatric nurse should assess each family as an individual within the context of tribal themes which underlie the cultural group.

* Suzanne Phillips, M.S.N., R.N., Assistant Professor, Pediatric Nursing, Family/Community Department, Florida International University School of Nursing North Miami Campus, North Miami, Florida 33131

‡ Sandra L. Lobar, M.S.N., R.N., Assistant Professor Family/Community Department, Florida International University School of Nursing North Miami Campus, North Miami, Florida 33131

Tribal Themes

To the Navajo, traditional social institutions play an important role in their daily lives. A network of kinships and relationships centered in people form the basis for certain themes which prevail throughout the Navajo society. Three tribal themes described by Downs (1972) are matriarchy, the inviolability of the individual, and the prestige of age. These themes influence childrearing practices among the Navajo.

The first tribal theme of matriarchy expresses the importance of the female. In daily life the important social units are those centering around a core of women—grandmother, mother, daughter, sisters, and their sons and brothers. Husbands and sons-in-law play a more peripheral role. Children consider themselves part of the descent group of their mother. The relationship between brother and sister is important and often overrides the relationship between husband and wife. A mother's sibling's children play almost as important a role in her life as do her own children, and children of a sister are more significant than the children of a brother. Since children tend to remain with their mother in dissolved marriages, the mother may have children from several marriages living with her. The Navajo family unit refers not only to the nuclear family, but also to other relatives as well—mother, aunts, sisters, and their female descendants. These individuals of the extended family make up a clan. Shared maternal responsibilities foster the extended family attachment relationships (Satz, 1982). The nurse should be aware that although the Navajo child may be isolated on the reservation in a geographical way, he or she is rarely isolated from meaningful and supportive social relationships within the clan.

A second tribal theme is the inviolability of the individual. Despite close familial ties, the Navajos remain highly individualistic people. Their primary social premise is that no person has the right to speak for or direct the actions of another. This theme may have implications in disciplining Navajo children, and in obtaining a child's health history from a parent or other relative.

The third tribal theme is the prestige of age, particularly age coupled with a life of hard work and many children and grandchildren. Within the nuclear family there is a clear deference to age. A man with many descendants, although poor, will be listened to with respect. Therefore, the birth of a child is welcomed by the Navajo clan and considered an asset to the family.

Health-Illness Values and Beliefs

Leininger (1988) discusses the world view which refers to "the way people tend to look upon the world

or universe to form a picture or value stance about their life or world about them" (p. 156). The prevailing world view held by a specific cultural group is the basis for their ideas or theories about health and illness causation. American Indians usually demonstrate a holistic world view. Within this holistic paradigm, the personified force of nature is kept in balance or harmony. Nature is composed of many things, including human life, which is seen as part of the general order of the cosmos (Boyle & Andrews, 1989). In traditional Navajo culture, illness occurs when a person falls out of harmony with the forces of nature. Rituals restore the harmony which has been disrupted so that the body can heal itself. Disease can occur from a multitude of sources—infections from enemies or animals, natural phenomena such as wind or lightning, witchcraft, evil spirits, improper behavior, breaking of taboos, or neglect at ceremonies. The healing process can be broken down into several categories: recognition of disease, diagnosis, symptomatic treatment, etiology, cure, and prevention (Porvaznik, 1967).

A specific hierarchy of practitioners summarized by Crockett (1971) exists to carry out the above functions. The highest person in the hierarchy is the Singer or Chanter, the high priest of the Navajo religion. He cures illness or restores harmony. He does not treat or relieve symptoms, and his important skill is learned by years of apprenticeship. Below the Singer is the Diagnostician who diagnoses the cause of the illness, and prescribes the proper Sing. His abilities come from a mystical source. He uses techniques such as stargazing or hand-trembling to diagnose and receives compensation for his services. The lowest practitioner in the hierarchy is the Herbalist who gives symptomatic relief until a ceremonial cure is arranged. Whatever relieves pain is resorted to—whether it is a Navajo Herbalist, a Hopi medicine man, a Christian faith healer, or a nonnative American physician. If the nonnative American physician is young, he or she has even less status.

Patterns of Behavior

The need for the nurse to make systematic and detailed assessment of the life patterns of an individual or cultural group with reference to health maintenance behavior has been emphasized by Leininger (1978). Reoccurring life patterns, such as childrearing practices, should be identified within the family's natural and familiar setting. Childrearing practices among the Navajo are closely tied to traditional and religious beliefs. Ceremonies (also known as Blessingways) and taboos play an important part in their daily lives. Awareness and understanding of these practices can increase the nurse's effectiveness in working with the Navajo families.

Arthur (1976) has identified four phases of childrearing practices among the traditional Navajo population. These phases are (1) pre-birth, (2) pre-cradleboard, (3) cradleboard, and (4) post-cradleboard.

Pre-birth phase

During the pre-birth phase, the mother is given recognition of the pregnancy by ceremonies, taboos, and herbal medicine. A primiparous mother is given special attention. Recognition by the extended family and community helps the mother accept the pregnancy as a reality, an important task noted by Rubin (1975) for a positive and successful pregnancy.

Navajo women concur that pregnancy is a well state, not an illness (Olds, Long, & Ladewig, 1988). Consequently, traditional Navajo prenatal beliefs and practices regarding exercise and activity have good physiological basis for maintaining a healthy fetus and can be supported by the nurse. The pregnant woman is encouraged to exercise regularly and to go about her chores, as this routine keeps her calm and happy. Heavy work, such as carrying and lifting heavy loads, chopping wood, and making jerking, twisting motions, is to be avoided since this may cause a premature delivery or kill the unborn child. She is also advised not to ride horseback or to do heavy lifting in the first and last months of pregnancy. The woman is encouraged to work and to walk regularly so that the baby does not grow too big and cause a difficult delivery (Arthur, 1976).

A longstanding Navajo belief is that the fetus has no mind of its own but is very much alive through the umbilical cord. Consequently, whatever affects the mother would influence the unborn child as well (Wyman, 1942). Since the baby is a welcome addition to the family, precautions must be taken to give the child a favorable start in life. Ceremonies and taboos ensure health, prosperity, and the general well-being of mother and baby. They protect both mother and child from harm and place them "in tune" with the Holy People who watch over the Navajo. Ceremonies are therapeutic to the mother since they result in a good attitude and less anxiety about the pregnancy and are also a protection against the breaking of taboos (Arthur, 1976). The midwife, grandmother, and Navajo practitioners are extremely important to the pregnant mother since they are well versed in traditions, taboos, and the ceremonial procedures which can influence the child's later talents and tendencies (Newcomb, 1940).

Conduct of the parents is important to the unborn child. Not only the mother, but also the father can influence the fetus (Satz, 1982). The father's participation in the ceremonies and practicing of taboos involves him prenatally with his child and enhances the attachment process. Many taboos are described

in the literature. For instance, knots tied by the mother or father should not be left tied, or the fetus will be tangled in the umbilical cord. If the ceremony of dry painting or body painting is witnessed by the parents, the child will have a severe illness during his life. If a pot is broken by the pregnant mother, the infant's soft spots will not close at the proper time or he will stutter. This affliction can be averted by breaking another pot over the infant's head after he is born so that the pieces fall beneath him in a pile (Evans & Fike, 1975). As Satz (1982) notes, pregnancy is a state of the living and the fetus should not be exposed to the realm of the dead. Neither parent should attend a funeral or go through a graveyard; otherwise the child may have nightmares. If either parent kills, skins, or sees a dead coyote, snake, or cat, the child will become sick.

Newcomb (1940) noted that baby clothes were not made until the infant was about 2 weeks old, a tradition probably reflective of the high infant mortality of years ago. It is the traditional Navajo belief that the infant would die before it could wear the new clothes. Even today, one of the authors found in her experience with the Navajo that the family will frequently delay buying baby clothes or making other provision for the baby until after birth. A nonnative American nurse may misinterpret the lack of physical preparation for infant as disinterest on the part of the Navajo family.

Pre-cradleboard phase

At the pre-cradleboard stage, a hogan is designated or built for an impending traditional birth. The Navajo religious practitioner or grandmother ties a red sash belt (for a girl) or buckskin rope (for a boy) to a log or ceiling rope to give the mother support during the delivery. A traditional midwife, a close female relative, and the Navajo practitioner may also be present to assist and to perform rituals. The newborn is gently shaken and massaged to stimulate breathing (Satz, 1982). After birth the child is washed in a basket of yucca suds, dried, and then placed in a mattress made out of the pulped bark of wild rose bushes. The baby is covered with soft buckskin and wrapped in a sheep pelt. Wild rose bush pulp is placed on the genital area. The pulp is very soft, has a pleasant natural smell, is highly absorbent, prevents odors, and is nonirritating—excellent diaper! When it becomes soiled by the infant, the pulp is disposed of or washed and replaced (Arthur, 1976). The infant's head is turned toward the hogan fire since in the Navajo religion the fire is a symbol of life and is sacred (Kluckhohn & Leighton, 1974).

The placenta is placed in the ashes of the hogan fire or else buried. Because the placenta is the "life tube" of the baby, the ashes are a safe spot since fire

combats evil spirits. Proper disposal of the placenta and cord ties the child to the land. The cord is disposed of by burying it in the proximity of the home. Where the cord is buried determines in which vocation the parents want the child to excel. For instance, the cord is buried in the stockyard so that a boy will become a good stockman, or by a loom so that a girl will become an artistic weaver (Arthur, 1976).

Traditionally, the baby is given to the mother or placed in a temporary cradle near her within a few hours after birth. This physical closeness continues until weaning and supports the attachment process (Kennell & Klaus, 1976). During the first four days of life, the baby is attended by the midwife or grandmother. The mother is allowed to rest and to recover from the delivery with the help of the extended family, a support practice which enables the mother to accomplish more easily the physiological restoration and psychosocial postpartum tasks described by Gruis (1977).

Infant feeding has religious significance for the traditional family. The midwife or grandmother may brew an emetic from juniper bark which causes the baby to rid itself of mucus. A ceremonial food of corn pollen and boiled water is then fed to the baby. Corn pollen is used because of its religious significance, enduring nature, reproductive attributes, nutrient qualities, and beauty. With the traditional Navajo mother, breast feeding is not begun until the mother's milk comes in (Arthur, 1976). However, many Navajo mothers now breastfeed soon after birth (Satz, 1982). After four days the mother assumes care, and a permanent cradleboard and infant name is planned (Arthur, 1976). Breastfeeding is on a demand schedule which is supported by current infant-feeding recommendations (Lawrence, 1985). The baby is put to breast when hungry and nurses until satiated. Although infant formulas have now become more popular, traditional Navajos feel that breastfed babies are considered healthier. A bottle-fed infant becomes too detached from the mother, and cow's milk infuses the child with faculties of animals (Leighton & Kluckhohn, 1948). Formulas for infant feeding during the first year of life are now widely available and more commonly used on the reservation. The Woman/Infant/Child Program, a federally funded supplement feeding and educational program, has made an impact on the nutritional status of the Navajo infant and child (Duzen, Carter, & Zwagg, 1976). When formula is used, ready-to-feed rather than concentrated or powdered formulas are encouraged in certain areas because of the lack of refrigeration, good sanitation, and safe water sources in the hogans.

Today, most Navajo mothers deliver in the hospital which can increase anxiety due to isolation from family and other significant persons. Hospital rules

need to be flexible to allow for family support. The father or another significant person should be allowed to attend the delivery and the mother should be encouraged to breastfeed. Hospital stays should be as short as possible to allow the mother to return to her family. Since the placenta and cord are usually not disposed of in the traditional Navajo way in the hospital, a traditional Navajo feels this contributes to the child's losing his personal identity, losing his cultural identity, and eventually leaving the Navajo society (Arthur, 1976). If the Navajo family desires to maintain tradition in a hospital setting, the nurse can make arrangements to allow the family to dispose of the placenta and cord in the proper way.

Chisholm (1983) found that Navajo infants are significantly less reactive and irritable both at birth and during the first year of life when compared with Anglo-American infants. Although Chisholm does not rule out genetic influences, he speculates that a behavioral self-selection may be caused by prenatal environmental factors, such as the lower blood pressures observed in pregnant Navajo women. After birth, maternal-infant interactions and familial socialization play more significant roles in observed behavioral differences. An infant is rubbed, pressed, and shaped by the traditional mother. This practice is to help "stiffen" legs and make him or her "beautiful" (Wyman, 1942). The tactile stimulation and attention the infant receives during that time further encourages attachment and optimal development (Kennell & Klaus, 1976).

During the first month the child is given a Navajo name. Many times children are given the name of a long-lived person or grandparent so that they too will live to an old age. The Navajo name protects the child and keeps him or her in tune with the Holy People. This name is kept secret until the proper ceremony. During their lives children are frequently given other names deliberately by inspiration, or just by general usage. The Navajo child may have a Navajo name, a kinship name, a nickname, and a European name, which is very confusing to outsiders and personnel in medical records. Infants may not be named until after their first laugh or when they begin to notice their surroundings (Kluckhohn & Leighton, 1974).

Making a fuss over a young child causes the family to become very uncomfortable. A stranger, by his or her attention, may "witch" a child, with the result that the child stutters, or is unable to talk in the future. Other taboos have been noted in the literature. If a child's hair is cut before he talks, he will stutter or have difficulty with speech. If a mirror is held up to a baby, he will go blind. If the baby is given things a stranger really likes, he may die.

Some taboos show good insight into meeting the child's emotional and physical needs. Babies should

not be hit in the mouth, or they will be stubborn. An infant should not be teased or hurt, or the teaser will become "bad." A baby's head should not be allowed to stay to one side on the cradleboard, or it will have a wide head (Evans & Fike, 1975).

Cradleboard phase

During the cradleboard phase, the baby's first laugh is celebrated. The first laugh indicates that the child has developed a maturity and self-identity. The celebration will cause the child to be generous, kind, and happy. A sheep is killed; a feast is given; and small amounts of salt are distributed to the relatives (Arthur, 1976). A nurse who elicits the infant's first laugh may be expected to give a gift to the child or even given the honor of underwriting the feast.

During this phase the child is placed in a permanent cradleboard. The traditional Navajo will use two cradleboards. The first has a face cover and is discarded as soon as the child is well assured of survival. To the Navajo, the second cradleboard has both traditional and religious significance. Songs and prayers are chanted before journeying to the forest to obtain wood for making the board. The wood is selected by the father or grandfather, and it must be tall and straight—not struck by lightning or broken (Arthur, 1976).

The cradleboard serves as a protection for the baby and a convenience for the mother. It is like the womb—movement is restricted, support is present, and temperature changes are minimized. The child is placed in the board in an upright position after eating which helps digestion, and reduces reflux and regurgitation. The cradleboard provides warmth and security to the child, and minimizes the traumatic changes that take place at birth. A cradleboard also helps to promote communication between the child and other persons since it brings an infant to the same eye level as the adults. The propped position of the cradleboard acts as a safety device since it protects the baby from being stepped on by scuffling siblings or inattentive adults. A canopy over the board guards the infant's eyes against the sun and protects against head injury if accidentally dropped. Swaddling also protects against animal attacks. The board may actually promote walking since the child's balance and vision are already on the same plane. Chisholm (1983) found that the cradleboard does not delay motor skill development. When the child begins creeping, the board can be used as a temporary restraint if adults are not present to protect an infant from the fire. Generally, the cradleboard decreases conflicts and reduces frustrations between the child and the busy mother (Arthur, 1976).

In past years, hip dysplasias may have been exacerbated by the cradleboard practice. However, Rabin,

Barnett, Arnold, Freiburger, and Brooks (1965) found that hip dysplasias have decreased since the use of modern diapers. They concluded that the cradleboard used with disposable or cloth diapers tightly binds the hips in a slightly abducted position, the basis for treating the hip dysplasia. If further treatment is needed, the cradleboard can be modified to accommodate splints, casts, or braces.

Language skills are acquired by the child through someone's constant talking to him/her giving words to imitate, repeating kinship terms, and praising for repeated sounds. Maximum attention is given to the child when he/she learns to walk. Everyone takes turns in leading the child around (Kluckhohn & Leighton, 1974).

Immunization deficiencies are no longer a major problem, but health clinic appointments may be missed because of transportation difficulties and lack of education regarding the importance of preventive care. Pediatric clinic personnel frequently should adjust immunization schedules to give maximum protection for a child.

Post-cradleboard phase

The main characteristics of the post-cradleboard phase are weaning, toilet training, and disciplining. The grandmother is often entrusted with the child-rearing of her young grandchildren. Her influence greatly impacts the sensitive early developmental years—Navajo tradition and language are well ingrained from generation to generation and fully in place by the time the child attends school. If a grandmother is not available, a sister or other relative may care for the child while the mother resumes work or school (Satz, 1982). This familial accommodation to the new child allows for less radical maternal role changes. The maternal-infant attachment remains strong, but the Navajo mother is also allowed to pursue individual interests with support of the extended family.

Weaning is introduced with a new pregnancy. If the mother is not pregnant, weaning is late and more gradual (Arthur, 1976). A disadvantage of late weaning is the prevalence of baby bottle mouth or dental caries in the primary teeth from milk or juice in the nap or bed bottle. Anticipatory guidance on weaning and nutrition is an important part of the well child care in the Navajo population. Solids are encouraged in the traditional Navajo population from the time that the baby can sit up. The child is offered any food that he can safely handle—bread dipped in broth or coffee, canned tomatoes, fruit, rice, cereal, soft cookies, and squash. He is weaned to a cup or bowl with weak sweetened liquids and encouraged to take squash, potatoes, and softened meat from a spoon (Kluckhohn & Leighton, 1974). In past years New-

comb (1940) found that some infants were fed salt since the Navajo Creation Myth indicates that infants fed this substance grew rapidly.

The most frequent traditional foods in the children's diet are potatoes, meat, bread, and cereal. Native dishes frequently involve the use of corn. Alford and Nance (1976) found that Navajo children's diets in isolated areas are frequently low in calories, borderline in protein, and deficient in Vitamin A and Vitamin C. Obesity was occasionally seen by one of the authors in well child clinics because the child is allowed the breast or bottle and high caloric foods "if he wants it," again an indication of the inviolability of the individual. Growth charts need to be monitored to detect early overfeeding and to begin nutritional education using Navajo staple foods as a foundation for counseling (Mandelbaum, 1983).

The Navajo have a relaxed attitude toward toilet training. Controlled bowel movements are not expected until the child is old enough to direct his or her own movements. Training is demonstrated and taught through modeling, and mother is quite patient, even with "accidents." Children may be half-clothed which facilitates changes. The Navajos believe that forcing toilet training will cause the child to be fearful (Arthur, 1976).

The Navajos' belief in the inviolability of the individual also plays a large part in their attitude toward discipline. A characteristic pattern is light discipline by persuasion, ridicule, or shame, in contrast to the corporeal punishment commonly seen in the Anglo-American population. Children are "herded" rather than led. An adult or older child tends to interpose and to divert the young child to another activity rather than to punish. Children's wishes are usually honored unless they are absolutely impossible. Adults may even rearrange their plans to accommodate the child (Downs, 1972). The child is allowed to explore and is responsible for his or her own actions. If a toddler is warned against touching a hot stove, he or she is responsible for that behavior, not the parents (Satz, 1982). Navajo children do not ordinarily ask permission to do certain things—they eat when they are hungry and sleep when they are tired. To the outsider the child may appear "spoiled" (Primeaux, 1977). But again, this behavior is a reflection of the Navajo belief that no one has the right to impose his will on another person.

The traditional Navajo also makes skillful use of terror to enforce proper behavior and to instill dependence on the family. From infancy onward the child is exposed to frightening experiences from which he is then extricated by his mother or older siblings. These experiences suggest to the infant mind that safety exists solely with the family. Older children will tell stories of evil beings to younger toddlers and

will produce more fear. Adults in turn tell fearful stories to older children. The idea that only with one's close relatives can one feel safe, and turning to them for comfort and protection is reinforced (Downs, 1972).

The Navajo father is required to provide for his children, to teach them properly, and to serve as a role model. If the father is absent, the mother's brother may assume some obligations toward her children. There are some differences in the behavior of children toward their mother and father. Children will usually approach their mother directly to ask a favor or for help. Girls are reluctant to approach their father and tend to use the mother as an intermediary. Fathers and sons have a more direct relationship. Between siblings, age is a great determiner of authority and attitude. The elder will assume authority over and care for the younger siblings throughout life (Downs, 1972).

Children are required to assume responsibilities, such as herding, as soon as they are able. Skills are developed as part of childhood play. Children grow up with animals and show little fear of them. Their lives are ones of experiential learning arranged to provide them with opportunities to develop skills and confidence. By the time children are three, they are allowed to participate in herding activities by "helping"—they may actually hinder the operation, but they are not discouraged. At 6-7 years of age, they may accompany the herder to the range, and may take over full herding responsibility at 8-10 years of age.

Toys are few and shared by all. Girls have dolls and the boys' most prized possessions are usually their ropes. The skill in rope handling carries much prestige. Riding is learned early. At about 12 years of age, an adult (such as the father or uncle) will take the boy for a ride, evaluate his behavior on a horse, and if he passes the test, he is considered an adult. Thereafter he is expected to cope with the adult dangers of life (Downs, 1972).

The first menstrual period of a girl is announced by a four-day ceremony or "kinaalda," a pubertal ceremony (Frisbie, 1967). The Navajo believe that during this period of her life the girl is particularly sensitive to influences that will affect her later life. She is a plastic mold that can be easily injured, needs to be properly shaped, and is the center of continuous ceremonial songs, prayers, and purification rites by her relatives during this time (Downs, 1972).

Generally, the Navajo children are taught a positive self-concept by being allowed to succeed at tasks at their age level. Although there is evidence that they demonstrate poor self-concept in the outside world, in their own world they are highly competitive and think highly of themselves. To call attention to oneself is "showy," and this may result in poor academic performance. There is also a cultural prohibi-

tion, which is encouraged in the children at an early age, against overt expression of anger and aggression. Self-discipline and independence strivings are always rewarded and emphasized in all childhood training (Primeaux, 1977).

Nursing Care

Cultural care preservation or maintenance, according to Leininger (1988), refers to "those assistive, supportive, or enabling professional actions and decisions that help clients of a particular culture to preserve or maintain a state of health or to recover from illness and to face death" (p. 156). Brandt (1978) discusses the Navajo child's concept of health and reactions to hospitalization. The family's concept of health impacts on their decision concerning their choice of health care providers, whether it be a traditional health agent, a non-Navajo health agent, or a combination thereof. A pathophysiological explanation which excludes a holistic health care approach may cause the family to retreat from the health care regimen.

The nursing process can assist the nurse to understand the Navajo world. Through assessment of the cultural aspects of the family's lifestyle, health beliefs, and practices, the nurse can better facilitate shared decision-making while providing holistic care. Culturally sensitive interventions are relevant to the clients' needs and can reduce stress and conflict with nurse-family interactions (Boyle & Andrews, 1989). As the process moves from assessment (e.g. what are the Navajo family's working beliefs, traditions, practices?) through evaluation (have those beliefs, traditions, and practices been violated or maintained?), the nurse can validate his or her helpfulness while caring for the Navajo child (Mott, 1985). Active listening to elicit pre-existing beliefs allows the nurse to incorporate those beliefs into health service contacts and education (Maheady, 1986).

Navajo children as patients are usually shy and fearful of strangers. Older children may be stoic and noncomplaining. They are not prone to look at caregivers directly, they generally have little eye contact (a sign of respect), or say "thank you" and "please." During conversations, there may be brief silences after each speaker's words to show respect and to reflect on what was said (Kniep-Hardy & Burkhardt, 1977). The Navajo tend not to use touch for communicating comfort as much as other cultures do. Older children may be more comfortable with physical closeness rather than with frequent touching from a caregiver.

Visits by relatives are expected by the family and ill child and are comforting to them. The grandmother is especially important, and her permission

may be needed for hospitalization or other procedures. In kinship terms, several persons may be designated as "mother" or "grandmother" which is confusing to the nurse, although perfectly understandable to the child (Kniep-Hardy & Burkhardt, 1977). Family members should be supported and encouraged in their child-care activities to decrease anxiety of both the child and the relatives.

Room and privacy should be allowed for a Sing if that is requested. Rituals such as sprinkling cornmeal on an ill child or allowing the possession of a curative item will reduce anxiety and unnecessary conflicts with the family. The cornmeal should be saved — not discarded without family permission. Medicines given to a child by a Navajo health practitioner during a ceremony should be cleared with the physician to avoid unfavorable reactions, but this is rarely a problem (Primeaux, 1977).

Problems with medication scheduling may occur because the Navajo does not have the same time sense that the Anglos do. Indian time is casual and relative. Meals are eaten at different intervals and pills may be taken all at once rather than throughout the day (Primeaux, 1977). Careful explanations are needed to prevent misunderstandings by parents. Problems also can arise in translations of medical terminology, as certain concepts are difficult to translate from one language to another. A Navajo health care worker can decrease translation difficulties during counseling and should have good insight into potential difficulties for carrying out therapeutic actions.

Death is seen as a part of life, and children are not shielded from it. However, after the traditional mourning period of 4 days, an excessive display of emotion is not looked on favorably, and there is a fear of the power of the dead person (Miller & Schoenfeld, 1973).

The Navajo people have a rich heritage which has sustained itself remarkably well through the centuries. Knowledge of that heritage is the first step in establishing a therapeutic relationship. Nurses have responsibility to individualize care based on an assessment of each family within the greater context of the Navajo belief system. A thorough review of the literature is one avenue that the nurse can use to establish a knowledge base for providing culturally specific care.

REFERENCES

- Alford, B., & Nance, E. B. (1976). Customary foods in the Navajo diet. *Journal of the American Dietetic Association*, 69 (5), 538-539.
- Arthur, B. J. (1976). *Traditional Navajo childrearing pattern: A survey of the traditional childrearing practices among elderly Navajo parents*. Unpublished master's thesis, University of Utah, Salt Lake City.
- Boyle, J. S. & Andrews, M. M. (1989). *Transcultural concepts in nursing care*. Boston: Scott, Foresman, Little Brown, Glenview, IL.
- Brandt, P. A. (1978). Two different worlds . . . the Navajo child's interactions within the health care system. In M. M. Leininger, (Ed.), *Transcultural nursing: Concepts, theories, and practices* (pp 251-266). New York: J. Wiley & Sons.
- Chisholm, J. S. (1983). *Navajo infancy*. New York: Aldine.
- Crockett, D. C. (1971). Medicine among the American Indians. *HSMHA Health Reports*, 86 (5), 399-401.
- Downs, J. F. (1972). *The Navajo*. New York: Holt, Rinehart, & Winston.
- Duzan, J. V., Carter, J. P., & Zwagg, R. V. (1976). Protein and caloric malnutrition among Navajo Indian pre-school children—A follow-up. *American Journal of Clinical Nutrition*, 29 (6), 657-662.
- Evans, P. C. & Fike, J. (1975). The Navajo way: As related to pregnancy, childbearing, and child-rearing. *Arizona Medicine*, 32 (2), 97-99.
- Frisbie, C. (1967). *Kinaalda*. Middletown, CN: Wesleyan University Press.
- Gruis, M. (1977). Beyond maternity, postpartum concern of mothers. *Maternal Child Nursing*, 2 (3), 182-188.
- Kennell, J., & Klaus, M. (1976). *Maternal-infant bonding*. St. Louis: C. V. Mosby.
- Kluckhohn, C., & Leighton, D. C. (1974). *The Navajo* (rev.ed.). Cambridge, MA: Harvard University Press.
- Kniep-Hardy, M. & Burkhardt, M. (1977). Nursing the Navajo. *American Journal of Nursing*, 77 (1), 95-96.
- Lawrence, R. (1985). *Breastfeeding: A guide for the medical profession* (2nd ed.). St. Louis: C.V. Mosby.
- Leighton, D. C., & Kluckhohn, C. (1948). *Children of the people*. Cambridge, MA: Howard University Press.
- Leininger, M. M. (1978). *Transcultural nursing: Concepts, theories and practices*. New York: J. Wiley & Sons.
- Leininger, M. M. (1988). Leininger's theory of nursing: Cultural diversity and universality. *Nursing Science Quarterly*, 1 (4), 152-160.
- Maheady, D. C. (1986). Cultural assessment of children. *Maternal Child Nursing*, 11 (2), 128.
- Mandelbaum, J. L. (1983). The foodsquare: Helping people of different cultures understand balanced diets. *Pediatric Nursing*, 9 (1), 20-21.
- Miller, S. I., & Schoenfeld, L. (1973). Grief in the Navajo: Psychodynamics and culture. *International Journal of Social Psychiatry*, 19, 187-191.
- Mott, S. R., Fazekas, N. F., & Rowen, S. J. (1985). *Nursing care of children and families*. Menlo Park, CA: Addison-Wesley.
- Newcomb, F. J. (1940). *Navajo omens and taboos*. Santa Fe: Rydal Press.
- Olds, S. B., London, M. L., & Ladewig, P. A. (1988). *Maternal newborn nursing* (3rd ed.). Menlo Park, CA: Addison-Wesley.
- Porvaznik, W. (1967). Traditional Navajo medicine. *General Practitioner*, 36 (4), 179-182.
- Primeaux, M. (1977). Caring for the American Indian patient. *American Journal of Nursing*, 77 (1), 91-94.
- Rabin, D. L., Barnett, C. R. Arnold, W. D. Freiburger, R. H., & Brooks, G. (1965). Untreated congenital hip dysplasia: A study of the epidemiology, natural history, and social aspects of the disease in the Navajo population. *American Journal of Public Health*, 55 (Supp. 1), 3-15.
- Rubin, R. (1975). Maternal tasks in pregnancy. *Maternal Child Nursing*, 4 (3), 145-153.
- Satz, K. J. (1982). Integrating Navajo tradition into maternal-child nursing. *Image*, 14 (3), 89-92.
- U. S. Department of Health & Human Services. (1986, April). *Indian health service chart series book*. Public Health Service, Program Statistics Branch, Rockville, Maryland.
- Wyman, L. C. (1942). *Navajo eschatology*. Albuquerque, NM: University of New Mexico Bulletin.