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Embracing the Healing Journey

In November 2007, several Health Canada officials embarked on a journey, through the First Nation Communities in Crisis Initiative (FNCICI), to better understand what contributes to crisis situations in First Nation communities and how best to address these situations. That journey is expected to lead to the development of an evidence-based framework and action strategies to guide responses to future crisis situations.

With the support of the First Nation and Inuit Health Branch (FNIHB) of Health Canada, the National Aboriginal Health Organization (NAHO) commissioned a series of multi-disciplinary research papers that explore various dimensions of First Nation crisis. This edition of the Journal of Aboriginal Health presents the results of that work, which aims to provoke an informed debate that will support positive change.

Guiding Principles to support First Nations Communities in Crisis

The research identifies several key principles to guide those seeking to support First Nation communities at risk of, or recovering from, crisis:

Holistic Approach: The Aboriginal concept of health is holistic as reflected in the medicine wheel with its four dimensions: mental, physical, spiritual, and emotional. These four dimensions correspond to what “western” authors refer to as the social determinants of health. The path to healing and wellness requires that each of the four dimensions be addressed.

Strengths-based Approach – Evidence supports approaches to Aboriginal healing based on an assessment of a community’s strengths, not just its weaknesses, gaps, or poorer health outcomes. Building on and leveraging existing strengths is an effective method to moving forward.

Community-centred: A community must “own” its problem and be willing to take charge of its approach to healing. The role of government in these situations is to provide support through fiscal resources and expertise. Governments must avoid being prescriptive in their approach and recognize that healing will happen when the community wants it to happen.

Community Resilience: Perceiving crisis as a static issue of capacity equates to victimization. However, when viewed as transformational it can lead to the development and deployment of strategies that enable the community to move beyond vulnerability to being resilient, resistant and, ultimately, thriving.

Horizontality: Given that multiple federal government department mandates address the social determinants of First Nation community health, there is a need to work together effectively in a manner that promotes cooperation at all levels.

There is an overwhelmingly consistent finding in the research that confirms colonization contributed significantly to the imbalance of social determinants of health in First Nation communities evident today. Nevertheless, evidence demonstrates that many communities are healthy despite this history and the FNCICI is intent on learning and understanding more about the strengths of these communities, to better assist communities that are struggling.

Furthermore, the forces that contribute to crises in First Nation communities are multi-dimensional, inter-generational and complex. For this reason, an indigenous world-view in deconstructing crisis is essential to knowing how to move forward.

Going Forward

There are a number of obvious next steps to move this initiative from theory to practice. First and foremost, more discussion is required with First Nations and their organizations, non-governmental organizations (NGOs), the private sector, and within government to solidify the evidence base which will support the framework being developed, encourage buy-in to the direction being proposed and identify pilot projects to test the theoretical underpinnings.

In addition, we need to focus on:

- Learning from past experiences of communities that have both succumbed to, and successfully resisted crisis.
- Creating cross-departmental structures to facilitate cooperation.
- Advocating for a whole-of-government approach that addresses the social determinants of health, which are the underlying causes of crisis.
- Identifying criteria that will enable us to proactively identify communities in crisis and those at-risk of crisis.

In closing, we are encouraged by the positive reception these research findings have received from government officials, researchers and practitioners. Working hand-in-hand with willing First Nation partners, we are moving forward to test the strategies identified in our work through a series of pilot projects. As we learn from these experiences, and from further exploration of the key concepts, we are confident useful strategies will emerge that will enable First Nations to build resilience and successfully move along their healing paths.

Finally, we would like to acknowledge and thank the National Aboriginal Health Organization for partnering with us to commission an impressive array of research. In particular we acknowledge the strong support provided by Andrea Aiabens, Research Coordinator, Mark Buell, Director, Communications and Research Unit, and especially Paulette Tremblay, Chief Executive Officer, for her enthusiastic willingness to work with us to gather a solid body of evidence to support the First Nation Communities in Crisis Initiative.

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En route pour le voyage vers la guérison

En novembre 2007, plusieurs fonctionnaires de Santé Canada se sont embarqués pour un voyage, à travers l'Initiative sur les communautés en crise des Premières nations en crise (ICECPN), en vue de mieux comprendre ce qui contribue aux situations de crise au sein des communautés des Premières nations et de trouver la meilleure façon d'aborder ces situations. Ce voyage doit mener à la création d'un cadre basé sur des preuves et au développement de stratégies d'action permettant de guider les interventions face aux futures situations de crise.

Avec le soutien de la Direction générale de la santé des Premières nations et des Inuits (DGSPNI) de Santé Canada, l'Organisation nationale de la santé autochtone (ONSA) a commandé une série de documents de recherche multidisciplinaire pour explorer les diverses dimensions de la crise au sein des Premières nations. Cette édition du Journal de la santé autochtone présente les résultats de ces travaux en vue de lancer un débat éclairé pour soutenir un changement positif.

Principes directeurs du soutien aux communautés en crise des Premières nations

La recherche a identifié plusieurs principes clés pour guider ceux qui s'efforcent de soutenir les communautés des Premières nations risquant une crise à venir ou celles qui se remettent d'une crise passée :

Approche globale : Le concept autochtone de santé est global comme le montre la roue médicinale avec ses quatre dimensions : mentale, physique, spirituelle et émotive. Ces quatre dimensions correspondent à ce que les auteurs « blancs » ont baptisé les déterminants sociaux de la santé. La voie vers la guérison et le bien-être ne s'ouvre que si l'on traite simultanément ces quatre dimensions.

Approches basées sur les forces – L'évidence soutient des approches de la guérison chez les Autochtones qui sont basées sur une évaluation des forces d'une communauté et non pas seulement de ses faiblesses, des écarts ou des résultats en termes de plus mauvaise santé. S'appuyer sur et optimiser les forces existantes est une méthode efficace de progression.

Centré sur la communauté : Une communauté doit « s'approprier » ses problèmes et accepter de prendre en charge son approche de la guérison. Dans ces situations, le rôle du gouvernement est de fournir un soutien sous forme de ressources fiscales et d'expertise. Les gouvernements doivent s'abstenir de prescrire, dans leur approche et reconnaître que la guérison surviendra quand la communauté le décidera.

Résilience de la communauté : Ne voir dans une crise qu'une question statique de capacité, équivaut à une victimisation. Cependant, lorsqu'on la voit comme une

possibilité de transformation, cela peut mener à l'élaboration et à l'application de stratégies permettant à la communauté de dépasser sa vulnérabilité et de devenir résiliente, de résister et finalement de prospérer.

Horizontalement : Étant donné que les mandats multiples des ministères fédéraux traitent des déterminants sociaux de la santé au sein des communautés des Premières nations, il est nécessaire de travailler efficacement ensemble, d'une manière qui encourage la collaboration à tous les niveaux.

Des constatations remarquablement constantes dans les recherches, confirment aujourd'hui que la colonisation a bel et bien contribué de façon importante au déséquilibre des déterminants sociaux de la santé au sein des communautés des Premières nations. Néanmoins, il apparaît tout aussi évident que de nombreuses communautés sont en bonne santé en dépit de l'histoire et l'ICECPN a pour but de découvrir et de mieux comprendre les forces de ces communautés, pour mieux aider celles qui sont en difficulté.

De plus, les forces qui contribuent aux crises au sein des communautés des Premières nations sont multidimensionnelles, inter-générationnelles et complexes. Pour cette raison, une vue indigène du monde est essentielle, dans le désamorçage des crises, pour savoir comment aller de l'avant.

Aller de l'avant

Il y a de nombreuses et évidentes prochaines étapes pour faire passer cette initiative de la théorie à la pratique. D'abord et avant tout, plus de discussions sont nécessaires avec les Premières nations et leurs organisations, des organisations non gouvernementales (ONG), le secteur privé

et à l'intérieur même du gouvernement, pour consolider la base de preuves qui soutiendra le cadre en cours de développement, encourager l'adhésion à l'orientation proposée et identifier les projets pilotes qui permettront d'en tester la théorie sous-jacente.

De plus, nous devons nous concentrer sur :

- Retenir des expériences passées de communautés qui ont succombé et qui ont résisté avec succès à des crises.
- Créer des structures interministérielles pour faciliter la collaboration.
- Défendre une approche pangouvernementale pour aborder les déterminants sociaux de la santé qui sont les causes sous-jacentes des crises.
- Définir les critères qui nous permettront d'identifier proactivement les communautés en crise et celles à risque.

Pour conclure, nous sommes encouragés par la réception positive que ces résultats des recherches ont reçue, de la part des fonctionnaires du gouvernement, des chercheurs et des praticiens. En étroite collaboration avec des partenaires consentants des Premières nations, nous allons de l'avant pour tester les stratégies identifiées à travers une série de projets pilotes. Nous sommes confiants que des leçons de ces expériences et aussi d'une exploration plus approfondie des principaux concepts, émergeront des stratégies utiles qui permettront aux Premières nations de développer leur résilience et de continuer d'avancer sur les voies de leur guérison.

Finalement, nous voudrions remercier l'Organisation nationale de la santé autochtone de s'être jointe à nous pour commander cette panoplie impressionnante de recherches. Nous remercions en particulier Andrea Aiabens, coordonnatrice de la recherche et Mark Buell, directeur de l'Unité de la recherche et des communications, pour leur soutien sans faille, ainsi que Paulette Tremblay, la directrice générale, pour sa collaboration enthousiaste à la cueillette de preuves solides pour soutenir l'Initiative sur les communautés en crise des Premières nations.

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Par le biais de sa Direction générale de la santé des Premières nations et des Inuits, Santé Canada a fourni à l'ONSA un financement sur deux ans, pour couvrir le coût des contrats avec les auteurs et d'un coordonnateur pour ces contrats, ainsi que les coûts de traduction des documents et de la publication de cette édition spéciale en trois issues du Journal.

Language and Culture as Protective Factors for At-Risk Communities

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ABSTRACT

A comprehensive review and analysis of the literature related to the role of Indigenous language and culture in maintaining and improving the health as well as reducing the risk factors for health problems of Indigenous people. Although much literature exists on various topics related to culture, language and health, the specific focus of this paper was studying the effects of the use of language and culture on the health of Indigenous people. Once all relevant literature was gathered, six linked themes emerged as protective factors against health issues; land and health, traditional medicine, spirituality, traditional foods, traditional activities and language. Findings included evidence that the use of Indigenous languages and cultures do have positive effects on the health and wellness of Indigenous people. However, the majority of the existing literature focuses on culture and its effects on health. Therefore, more studies are needed specifically on the potential health benefits of Indigenous language use. Other recommendations for ways forward include more targeted research on urban Indigenous populations, and making links between the loss of traditional land, contaminants in the food chain and the health of Indigenous people in Canada.

KEYWORDS

Indigenous, Aboriginal, culture, language, health, protective factors

INTRODUCTION

Traditional language and culture have an important and sacred role to play in Aboriginal communities all across Canada. Many communities assert that their language and culture is at the heart of what makes them unique and what has kept them alive in the face of more than 150 years of colonial rule. But what role does the use of traditional language and culture play in maintaining health and reducing risk factors for health crises in Aboriginal communities? It is the aim of this paper to answer this question. A comprehensive search was conducted for literature that discusses traditional language and culture as protective factors of health outcomes for Aboriginal people.

Studies have shown that although the health of Aboriginal communities has improved over time, Aboriginal people are still not faring as well as the general population (Health Canada, 2001; Young, 2003). The effect of colonization on the health status of Aboriginal people continues to be profound (Bjerregaard & Curtis, 2002; Hurst & Nader, 2006). Given the overall health statistics of Aboriginal communities in Canada, it is clear that Aboriginal people are at a greater risk of developing serious health problems than the general population (Hurst & Nader, 2006; Minore & Katt, 2007). Whether it is the rate of diabetes, obesity, smoking, the effects of violence, cardiovascular disease, lower life expectancy, mental health

issues, suicide rates, substance misuse, cancer rates, or disease from environmental degradation, Aboriginal people in Canada have good reason to be concerned (Bjerregaard & Curtis, 2002; Health Canada, 2000; Hurst & Nader, 2006; Minore & Katt, 2007; Public Health Agency of Canada, 2004; Wilson & Rosenberg, 2002).

All indigenous languages in Canada are seriously endangered and most are at risk of extinction (Brittain, 2002; Shaw, 2001; Standing Committee on Aboriginal Affairs, 1990). Unlike other minority groups, Aboriginal people cannot rely on new immigrants to maintain or increase the number of speakers (Hallett, Chandler & Lalonde, 2007; Norris, 1998), nor is there a 'homeland' of speakers somewhere else in the world that they can visit if the language ceases to be used in Canada. It is estimated that at the time of contact there were 450 Aboriginal languages and dialects in Canada belonging to 11 language families¹ (Office of the Commissioner of Official Languages, 1992). In the last 100 years alone, at least ten of Canada's Aboriginal languages have become extinct (Norris, 1998). There are now approximately 60 indigenous languages still spoken in Canada belonging to 11 language families (Statistics Canada, 2008; Shaw, 2001; Kirkness, 1998; Norris, 2007; Royal Commission on Aboriginal Peoples, 1996). The precise number is difficult to determine because many languages are not standardized making counting dialects complicated (Royal Commission on Aboriginal Peoples, 1996). Only three of these 60+ languages (Cree, Inuktitut and Anishnaabe) are expected to remain and flourish in Aboriginal communities due to their population base (Burnaby, 1996; Norris, 1998). Between 1986 and 2001, the percentage of young children (aged 0-4) who speak their heritage language declined from 10.7 per cent to 7.9 per cent, while 5-14 years old speakers declined from 19.8 per cent to 16.7 per cent despite a growing population of young people (Norris & MacCon, 2003).

In order to understand the impact of these statistics we must remember that "the younger the speakers, the healthier the language" (Norris, 1998, p. 12). This translates to a dangerous situation in Canada as the statistics show that in many communities, fewer and fewer children and young people are learning their heritage language. Following decades of government imposed bans on many traditional cultural practices such as Sundances and Potlatch ceremonies, in addition to widespread punishment for generations of children for speaking their language while at residential schools, many Aboriginal communities are in the process of rebuilding the use and practice of their languages and cultures. The 2006 Census, however, reports more hopeful results. The number of Aboriginal people who

reported speaking an indigenous language held steady from the previous census (Statistics Canada, 2008). However, we still know little about the link between a healthy uptake of language and culture in a community and the state of health of its members.

DEFINITION OF KEY TERMS

Aboriginal and Indigenous

These two terms are used interchangeably to refer to the First Peoples of Turtle Island also known as Canada, which includes First Nations, Inuit and Métis. Any other direct reference to these individual groups or others (such as Native American) is intentional as the literature quoted may be specific to the named group.

Health

Aboriginal peoples generally define health more broadly than one's overall physical condition. Rather health is seen as wholistic, encompassing all parts of oneself including physical, mental, emotional, and spiritual wellness.

Culture

Systems of belief, values, customs, and traditions that are transmitted from generation to generation through teachings, ecological knowledge and time-honoured land-based practices. Culture take many forms which include (but are not limited to) ceremonies, methods of hunting, fishing and gathering foods, the gathering and use of traditional medicines, traditional diet, spiritual journeying, and traditional art forms such as drumming, dancing and singing. It is also important to recognize that culture is not static, it is dynamic and ever-changing and each community, particularly urban communities, may define and experience it differently.²

Protective factors

Language and culture are discussed throughout the paper as "protective factors." This phrase is used to capture the notion of conditions that build resilience, serving as buffers to the negative effects of risks (University of Wyoming, 2008) and at times have the ability to prevent risk factors all-together (Helping America's youth, 2008).

METHODOLOGY

The majority of literature was accessed using online databases such as Academic Search Premier, PsycINFO,

PubMed, Medline, Native Health Database, ERIC, MLA Bibliography, Native North American Bibliography, and First Nations Periodical Index as well as online search engines such as Google Scholar. Grey literature was sought through internet searching using Google as well as the Proquest Thesis and Dissertations database, the Canadian Health Research Database and the Canadian Public Policy Collections. Various combinations of the following keywords were used; *Aboriginal, Indigenous, Inuit, Metis, Indian, American Indian, Native American, First Nations AND culture, language, traditional AND mental, physical, spiritual, health, wellness, or well-being AND protective factors or resilience*. The literature included was English-language only, published in the last 10-15 years up to and including fall 2008.

There is a great deal of literature published on the link between indigenous culture and health. However, a great majority of this literature concentrates on the delivery of health services and ways to make this more “culturally-appropriate” as well as removing language and cultural barriers to accessing health services. Literature of this kind was not included in the review, as it did not capture the essence of the purpose of the paper. Rather the focus was on studies that discussed the use of language or culture and the effects they had on the health of Aboriginal people.

Alternately, the published research addressing traditional indigenous language use as a protective factor to risk was quite sparse. Despite this, the existing research on this topic is quite powerful, drawing some of the sharpest conclusions and is supported by empirical research. It is also important to remember that many Indigenous people state that without language, culture cannot exist. Norris (1998) explains that language is one of the most tangible symbols of culture and group identity. Shaw (2004) further states that the loss of language is tied to a deep psychological loss of identity and culture. The Royal Commission on Aboriginal Peoples (1996) affirms that language is the main vehicle for cultural transference. Kirkness (1998) agrees, quoting the World Assembly of First Nations, “languages of Aboriginal people...are necessary for the transmission of concepts that are critical to Aboriginal culture, and must be retained in order that Aboriginal cultures may be perpetuated” (p. 96). Although the literature which highlights the positive effects of culture use is more abundant than that which focuses on language, since one cannot exist without the other it further strengthens the argument that perhaps more attention should be paid to how language use contributes to health outcomes.

SUMMARY OF LITERATURE

Traditional culture use as a protective factor

The literature related to culture selected for inclusion in this review were that which address the efficacy of traditional culture use and showed evidence of its positive contribution towards Aboriginal peoples' health and therefore could be categorized as a protective factor against risks of health crises. Efficacy and evidence were broadly defined from empirical research to personal testimony. Using these criteria, the following five themes emerged:

1) Connection between land and health

Two key studies were located which address the importance of land for the health of Aboriginal people. The first study, done by Kathleen Wilson (2003) of McMaster University, was comprised of 17 in-depth interviews from a Northern Ontario Anishinabek community that has a population of 126 on-reserve members. Her argument is based on the belief that “the land, as place, is an integral part of First Nations peoples' identity and health” (p. 83). Many authors believe that the relationship Aboriginal people have with the land shapes all areas of their life: the cultural, spiritual, emotional, physical, and social (Akiwenzie-Damm, 1996; Mercredi & Turpel, 1993; Shkilnyk, 1985). The individuals interviewed in Wilson's study conveyed how utilizing the land helps to maintain balance that is necessary for health.

Participants stated many links between land and health, including the belief that the land is alive and contributes to positive emotional and mental health (Wilson, 2003). Many participants in this study stated that they communicate with rocks and trees as a way of dealing with problems. “It doesn't matter where you go. If I have problems I take a walk in the bush. I talk to the trees and they listen. They take my problems away” (p. 90). Another participant comments on the emotional, mental and spiritual aspects of utilizing the land, “I hunt, I camp, I fish and I have always done that and I always feel good when I'm out there in the bush. To me it's almost like a cleansing. I can go out there and I just feel so good, like my mind gets so cleared. I love it” (p. 90). This statement embodies the notion of a direct link between the land and how it supports health and healing (Wilson, 2003).

The second study found a connection between health and land by Wolsko, Lardon, Hopkins and Ruppert (2006) and the Yup'ik people of Southwestern Alaska examining indigenous conceptions of wellness. The research team conducted six focus groups with a total of 64 Yup'ik adults from the Yukon-Kuskokwim Delta region of Alaska. Many

of the participants expressed that the subsistence lifestyle, which by definition is inextricably linked to the land, is at the core of wellness for Yup'ik people (Wolsko et al., 2006). One participant links traditional activities to mental health in a similar way to one of the participants in the previous study, "I go fishing and hunting, fishing in the ocean. It just makes your head clear, just the wind in your face, just sitting there" (p. 358). Another participant states, "You know, just walking out in the Tundra and looking at the surroundings. That's a form of stress release. To become part of nature is a form of stress release" (p. 359). The authors conclude that participants consistently emphasized that "the wilderness helps to both heal and sustain a sense of well-being" (p. 360).

Nancy Turner (2006), an ethnobotanist, shares many important insights in her report about traditional medicine, health and well-being of Indigenous people in Canada which includes explaining the deep relationship First Peoples have with "their home places and with the hundreds of species of plants and animals they live with and depend upon" (p. 18). She further states that caring for the land and species is seen as the responsibility of First Peoples and quotes Dawn Smith a Nuu-chah-nulth woman working at the University of Victoria, "if our environment is not healthy, how can we be healthy?" (Turner, 2006, p. 22).

2) Traditional medicine

Although the existence of traditional medicine goes back to time immemorial, little has been documented about the efficacy of it. This may be intentional on the part of traditional medicine people or a lack of connection between empirical research and how efficacy of traditional medicine can be measured. University of Saskatchewan professor James Waldram (2000) published a convincing article which aims to stimulate a further investigation into the judgment of the efficacy of traditional medicines. Waldram (2000) poses the distinction between curing and healing, the first of which emphasizes the removal of pathology, while the latter refers to a broader process of repairing multiple dimensions of oneself. He goes on to say, "[h]ealing...can be directed toward alleviating physical pain and suffering but often also concerns itself with repairing the emotional state, possibly even leaving the pathology itself unaltered" (p. 606). Also, he asserts that healing may be seen by Indigenous people as a lifelong process in which total recovery may never be achieved. His argument is an interesting and worthwhile distinction to consider when judging the efficacy of the use of traditional medicine as a contributor to Aboriginal people's health outcomes.

Mohawk scholar Dawn Martin Hill (2003) confirms

that the literature on indigenous medicine makes direct links to land, language and culture. Several authors give good evidence of the contribution that traditional medicine makes to the health of Aboriginal people, and in some cases, non-Aboriginal peoples (Waldram, Herring & Young, 2006; Wolsko et al., 2006; Ootoova et al., 2001; Turner, 2006). One recent example is the use of evergreen tree extracts and blueberry plant roots to control Type II diabetes (Floren, 2004). Some say that the efficacy of traditional medicine is as much about the person's belief in it as it is about the medicine itself, and that "true believers" are those most likely to be healed by traditional medicine, ceremonies and healers (Hill, 2008, p. 8). This illustrates the strong link between traditional medicine and spirituality. Although some might argue that personal testimonies are not "scientific evidence" the stories of successful use of traditional medicines are included as this is a necessary and legitimate source of data when investigating issues pertaining to indigenous traditions. For example, a participant in Wilson's (2003) study describes his belief that,

Harvesting medicine is medicine. I really think about the therapeutic aspect involved in knowing that you are out there being spiritually connected to Mother Earth and what she provides for you. You are picking plants and putting down tobacco, thanking her for what she has given but at the same time you are rejuvenating yourself. You are healing yourself within... (p. 90).

A Yup'ik participant from the focus groups done by Wolsko et al. (2006) relates his own witnessing of the effectiveness of traditional medicine, "When my uncle had TB, his mother had him drink Labrador tea. And when he went for a checkup they saw one of his lungs had healed" (p. 354).

An additional historic example is given in a Health Canada (1995) publication:

The early North American Indians were familiar with disease and knew how to prevent it. In fact, the Indians of the Quebec area came to the rescue of Jacques Cartier in the spring of 1535. The Indians advised him to feed the crew a tea made from the needles and bark of the eastern white cedar – one of the many foods they used which was a rich source of vitamin C. The men quickly regained their health and learned a valuable lesson (as cited in Milburn, 2004, p. 422).

3) Spirituality as a protective factor

Several important articles link spirituality as a protective

factor in buffering against health risks in indigenous communities. One particularly key piece was a literature review published in 2008 on resilience and indigenous spirituality (Fleming & Ledogar, 2008). They identify Marc Zimmerman and Les Whitbeck, whose studies are reviewed later in this paper, as the authors most associated with cultural involvement as a protective factor or buffer to health crises such as suicide. Fleming and Ledogar's (2008) review of the literature on spirituality as a resilience factor concludes that the contributions made are most specifically in relation to the risk areas of alcohol abuse and suicide. One study by Garrouette et al. (2003) interviewed 1456 American Indian youth and found a commitment to cultural spirituality was significantly associated with a reduction in suicide ideation and attempts.

The therapeutic benefits of spiritual practices such as smudging, sweat lodge ceremonies and other indigenous spiritual traditions have also been widely noted (Wilson, 2003; Waldram et al., 2006). A study done by Perry Kendall (2002), the BC Provincial Health Officer, highlights the transformation of the community of Esketemc which was once rife with alcoholism, violence, sexual abuse, and suicide. The leadership made a decision to try to turn things around and they largely credit the "conscious placing of spirituality in the center of this process" (Provincial Health Officer, 2002, p. 67) for their success through the rediscovery of spiritual traditions such as the sweat lodge and the sacred pipe among others things. Another study, conducted with Navajo families who used ceremonial treatment for asthma, showed that all of the families who participated in ceremonies for healing reported relief of the symptoms (Van Sickle, Morgan & Wright, 2003). However, they also reported the decline in asthma attacks to be short-lived ranging from one month to one year (Van Sickle et al., 2003). One might see this as proof that the ceremonies did not "cure" the affliction, yet western medicine also has no cure for asthma but rather has medicines to manage it. The study concludes that western medicine and indigenous ceremonial practices have the potential to work in tandem, however the greatest barrier is the cost of ceremonies which are not covered by medical plans (Van Sickle et al., 2003). It is important to note that there are several examples that exist of health centres that are attempting to incorporate both indigenous medicine and western biomedicine approaches (Maar, 2004; Province of Manitoba, 2008).

4) Traditional foods

Receveur, Boulay and Kuhnlein (1997) define traditional foods as both plant and animal harvested from the local environment. Michael Milburn (2004), a scholar from Cape Breton University, defines indigenous nutrition as "culturally

and bio-regionally specific food-related knowledge that results in a dietary pattern, meeting basic nutritional needs while avoiding Western diseases" (p. 421). He states further that, "Native foodways are based on an intimate and spiritual connection to the land, the plants, and the animals" (Milburn, 2004, p. 426). Receveur et al. (1997) warn against the effects of a shift away from a traditional food diet due to the losses of traditional systems and culture-specific knowledge which will inevitably increase diet-related chronic health conditions. Indigenous populations are already seeing the effects of a changing diet and lifestyle patterns with rates of diabetes three times the national average in Canada and higher rates of cardiovascular disease in American Indians (Milburn, 2004).

Milburn (2004) states, "Traditional diet and lifestyle patterns provide protection against western diseases, as rates of chronic, degenerative disease were historically very low in Indigenous populations" (p. 415). Medical doctor Denis Burkitt claims, "the only way we're going to reduce disease is to go backwards to the diet and lifestyle of our ancestors" (as cited in Milburn, 2004, p. 413). Borre's (1994) innovative study on the consumption of seal by the Inuit demonstrates that, "feeling good is dependent on eating the animals that are found in nature" (p. 6). Other authors also state that eating traditional foods leads to a feeling of good health whereas non-traditional foods are seen as weakening (Adelson, 2000; Mackey, 1998; O'Neil, Elias & Yassi, 1997). There are additional benefits to traditional food gathering besides dietary, such as higher levels of physical activity, a spiritual connection (Provincial Health Officer, 2002; Milburn, 2004; Wilson, 2003; Wolsko et al., 2006) and emotional healing benefits (Wilson, 2003). Milburn (2004) and Turner (2006) convey that in indigenous cultures there is no clear distinction between food and medicine, as food is medicine.

5) Traditional activities

The Canadian Census Aboriginal Peoples' Survey (Statistics Canada, 1991) defines participation in traditional activities as "traditional ways of doing things such as hunting, fishing, trapping, storytelling, traditional dancing, fiddle playing, jigging, arts and crafts, pow-wows, etc." (as cited in Wilson & Rosenberg, 2002, p. 2020). Based on variables included in the Aboriginal Peoples' Survey (APS), three were chosen as measures of attachment to traditional activities for Wilson and Rosenberg's (2002) study; they were participation in traditional activities, having spent time on the land in the last year acquiring food or teaching children traditional ways, and as a separate measure, acquired food through hunting, trapping or fishing. Their findings showed that Aboriginal people who spent time on the land and

acquired food through traditional ways were less likely to report being unhealthy compared to those who answered “no” to these questions. However, the measure of health status based on participation in traditional activities was not significant. Wilson and Rosenberg believe that the measure for participation in traditional activities was too crude and calls for “a more nuanced analysis of cultural attachment” (p. 2028). However, other authors have found participation in traditional activities to be an effective protective factor against adverse health conditions such as depression and substance abuse (LaFromboise, Hoyt, Oliver, & Whitbeck, 2006; Whitbeck, McMorris, Hoyt, Stubben, & LaFromboise, 2002; Zimmerman, Ramirez-Valles, Washienko, Walter, & Dyer, 1998). Lastly, a study with Inuit women in the Arctic also concluded that “loss of traditional practices and language” affected their well-being and that of their community (Healey & Meadows, 2008, p. 31).

The concept of enculturation is defined as the degree to which an individual is maintaining one’s cultural identity by embedding oneself in traditional cultural norms and values such as traditional language, practices and spirituality (Whitbeck, Chen, Hoyt, & Adams, 2004; Wolsko et al., 2006; Zimmerman et al., 1998). Enculturation as a protective factor against alcohol misuse is gaining evidence. Herman-Stahl, Spencer and Duncan (2003) report that American Indians with low orientation towards cultural practices are 4.4 times more likely to misuse alcohol compared with their peers who are more culturally oriented. Based on a three-year study of nine reserve communities, four in the US and five in Canada, Torres Stone, Whitbeck, Chen, Johnson, and Olson (2006) conclude that, “enculturation has a significant positive effect, and it remains the only significant predictor of alcohol cessation...” (p. 242). Whitbeck et al. (2002) strengthen this view, stating that of those included in their study the, “protective influence of tradition was greatest for those who reported above average levels of traditional activities” (p. 411).

A participatory action research project based out of the University of Victoria states that healing circles, traditional foods, cultural ceremonies, drumming and dancing groups, and athletics are important aspects of culture that have a “powerful positive and transformative impact on the individuals who engage in these activities” (Riecken et al., 2006, p. 278). Carolyn Kenny (1998) quotes Douglas Cardinal delivering a keynote address at the Fourth Annual Conference of the Canadian Aboriginal Science and Technology held at UBC, “[A]rt was not a separate world in our language. It was the way we lived” (p. 77). She goes on to describe expression as it exists in its many forms in Aboriginal communities such as ceremonies, song, dance, mask, and storytelling (Kenny, 1998). Indigenous psychologist Rod McCormick (1995) found in a study of indigenous healing

that expression was the most important factor rating it at 35 per cent in his list of themes of healing. These studies make a strong case for the use of culture through art as a protective factor of risk in Aboriginal communities.

Perhaps the most poignant example to date, Ghislaine Goudreau completed her doctoral dissertation with a study of the health benefits of hand drumming with an Aboriginal women’s group. Goudreau (2006) states, “Our bodies contain internal rhythms such as heart rate and brainwaves” (p. 18). She relates the natural phenomena of entrainment, a theory that states that external rhythms such as drumbeats have the ability to realign our internal body rhythms. Through her study, Goudreau is able to claim that it appears the drum is a tool that can be used to calm our body rhythms if we are under stress as well as boost the immune system. Also it has been shown that participating in drumming circles increases the number of beneficial “killer cells” in the body that seek out and destroy specific disease organisms (Bittman, Berk, Felten, & Westengard, 2001). Drumming can also increase the number of Alpha brain waves (Maxfield, 1990; Neher, 1962) and according to Friedman (2000), “Alpha brainwaves are associated with states of relaxation and general well-being” (p. 44). Participants in Goudreau’s drum group consider drumming as a way of praying, a way to connect to the spirits, have the potential to awaken the spirit, and as a tool to release emotions. In a more recent publication of Goudreau’s (2008) thesis research, she details that participants in her study also stated pain-relieving effects and a relief from mental stress through their participation in hand-drumming circles.

Resilience through “cultural capital”

The sociological term cultural capital is used to describe the transmission of educational advantage from one generation to the next (Sullivan, 2007). This concept is largely based on a Euro-western worldview of individual nuclear family units as the main source of cultural transference. However, many authors have been criticized for their narrow interpretation of this concept (Sullivan, 2007). Pacini-Ketchabaw and Bernhard (2001) expand the term to include the home language of immigrant families as a source of cultural capital. They argue that language is one of the most important practices for cultural production and reproduction and further state that, “the vitality of a language indicates how well a group is maintaining itself in society” (p. 7).

Traditional language use as a protective factor

Most of the literature found on the topic of traditional language use and health focuses on the negative effect of indigenous-only language use in the home which has the effect of lowering rates of access to health care (Bird, Wiles, Okalik, Kilabuk, & Egeland, 2008; Hahm, Lahiff, Barreto,

Shin, & Chen, 2008; Schumacher et al., 2008).

After many days of searching for any literature relating indigenous language use to increased health and wellness, or as a protective factor to risk of health crises, one article was finally located. It was published in 2007 by three researchers, two of whom (Michael Chandler and Chris Lalonde) are well-known and highly regarded for their research on factors which contribute to lower suicide rates in Canadian First Nations communities. The third author, Darcy Hallett, was a recent doctoral student of Michael Chandler. In their article they state, "as far as we have been able to determine, there are no previous studies that have attempted to demonstrate a specific link between indigenous language loss and community-level measures of health and wellbeing" (Hallett et al., 2007, p. 394). Based on the literature search conducted for this paper, this assessment appears to be accurate even in the fall of 2008. Despite this fact, the research they present is powerful and lends encouragement for further research in linking traditional language use specifically with health outcomes, and the potential it has to act as a protective factor against health risks.

Their recent work on language use as a protective factor stems from the seminal work of Chandler and Lalonde first published in 1998 where they studied five years of data on youth suicide rates in First Nations communities in British Columbia (Chandler & Lalonde, 1998). In the original work on youth suicide rates Chandler and Lalonde (1998) sought to offer some explanation for the wide variation of youth suicide rates in BC communities which ranged from no known suicides in over half of the 196 communities to 500-800 times the national average. They identified six measures of "cultural continuity" defined as 1) self-government, 2) engagement in land claims, 3) existence of education services, 4) tribal-controlled police and fire services, 5) on-reserve health services, and 6) existence of cultural facilities (Chandler & Lalonde, 1998). Communities which did not identify with any of the factors defined as indicators of cultural continuity (see above) were assigned a zero, while communities with all six factors present were assigned a six. Next, they compared youth suicide rates in each community against the existence of these six factors separately and then all-together as a score of 0 to 6. Those communities which had none of the factors present had a rate of suicide 137.5 per 100,000, a significant difference from those communities which had all six factors present and report zero suicides. Obviously a very convincing argument for the effect of these six factors; however, there has been criticism of their work. Some believe that the term 'cultural continuity' is misleading as none of the six factors may in fact be measuring the continuation

of culture in the community but rather local administrative control of their nation (Hallett, 2005). In his doctoral work, Hallett adds the measure of indigenous language knowledge to the mix of "cultural continuity" factors arguing that it holds the potential to be a more direct indicator of the role that cultural preservation plays (through language) in predicting the effects that cultural continuation has on creating healthier communities with fewer youth suicides.

In order to avoid the dangers of circularity, the indigenous language knowledge factor was analyzed separating from the other six pre-existing measures. The findings were significant; bands with higher levels of language knowledge (measured by a majority of its members having conversational-level abilities) had fewer suicides than those with lower levels (Hallett et al., 2007). In fact, the rates of suicide in the bands with high language knowledge levels were "well below the provincial averages for both Aboriginal and non-Aboriginal youth" (p. 396). What is further, when the language knowledge factor was added into the mix of the other six measures "the presence of the language factor made a drastic difference in suicide rates" (p. 397). In all cases but one, the suicide rate dropped to zero when the language factor was added (2007). Although Aboriginal language knowledge was found to have correlations with the other six measures, its independent contribution is significant. Hallett et al. state that overall, the results show that the use of indigenous languages is a "strong predictor of health and wellbeing in Canada's Aboriginal communities" (p. 398).

One other study was located which had an indigenous language component in its measurement of links to health outcomes and protective factors. Interestingly though, because of the remote geographic location in the arctic, virtually all community members were fluent speakers of the local indigenous language (Greenlandic) and therefore, the protective influence could not be measured (Bjerregaard & Curtis, 2002).

In conclusion, the link between language and culture for indigenous communities cannot be overemphasized. Although the research findings for this phenomena are limited to one study, the implications are important and the potential vast. Language is also often recognized as one of the most tangible symbols of culture and group identity (Blair, Rice, Wood, & Janvier, 2002; Norris, 1998), and the main vehicle for cultural transference (Norris & Jantzen, 2002; Royal Commission on Aboriginal Peoples, 1996). Without the language of one's ancestors, individual and collective identity gets weakened and it is likely that the culture would die out within a few generations. As conveyed by a group of indigenous language preservationists, no new songs could be written in our languages, ancient songs would no longer

be understood, we would no longer be able to communicate with the spirit world in our language and no one would be able to understand our sacred prayers (Indigenous Language Institute, 2002). Therefore although less abundant in findings, this area of research may very well be the most important of the subject matter at hand.

DISCUSSION

Context

Based on the literature review, it is clear that there are not a lot of in-depth studies examining the influences of cultural beliefs, values and language on health. The key studies reviewed, however, clearly indicate the positive influence of culture on Aboriginal communities and individuals.

In their study of traditional and contemporary Dene perspectives on health, Parlee and O'Neil (2007) argue that improving the applicability of health care requires rethinking not only medical practices but also the meaning of "health." As such, there are many shared or similar indigenous views and concepts related to the term. Traditionally, most Aboriginal cultures did not have a word for "health" because it was not seen as a separate entity but as part of a larger whole. In the western Cree dialect, the closest words describing health are *miyomahcihowin*—"feeling well" and *miyopimâtisowin*—"the good life." Both of these concepts are seen as antidotes to *ahkosowin*, the Cree word for sickness or "out-of-balance." The Lutsel K'e Dene describe health in their language as "the Dene way of life" (Parlee & O'Neil, 2007), and the Yup'ik Inuit word describing health similarly translates as "to live a good life" (Wolsko et al., 2006).

Like many Aboriginal cultures, central to the Yup'ik Inuit way of life is the practice of maintaining a balanced reciprocity between human, natural and spiritual realms. Many nations today describe this type of reciprocity and the rights and responsibilities that go with it as "traditional protocol." The Yup'ik have their own term for this process:

Critical to this ethic of care and respect is the cultivation of *ella*, translated generally as conscious awareness of the creative force which sustains a harmonious way of life (Wolsko et al., 2006, p. 348).

Maintaining a careful balance of reciprocity between realms is precisely what has sustained indigenous cultures since time immemorial. Many oral teachings supported by Elders and spiritual healers would maintain that it is a responsibility and duty of conscious individuals to strive for living within this conceptual framework. Not living

according to concepts such as *ella* leads to a falling out of balance, thereby creating an opening for sickness and other forms of ill-health. It is therefore something that is taken quite seriously by enculturated individuals and communities. These holistic core world-views are very closely related to many of the broader definitions of health and integrated approaches to wellness that are becoming more common to health professionals and caregivers as well as many culturally-oriented healing centres.

Holistic world-views are complex, especially to individuals who are not enculturated or familiar with an indigenous language or world view. Traditional core values, concepts and beliefs are clearly imbedded in the language of a particular culture. It is a common argument of traditionalists and language preservationists, that the more one understands their language and the teachings associated with that language, the more access they have to core traditional knowledge that can help them to develop a stronger sense of identity. If this is true than it can also be argued that the further one is separated from their language, the more disconnected they may be from the core traditional knowledge needed to develop a stronger sense of identity.

It is clear that Aboriginal language and culture, because of their inter-connected nature, may be difficult to analyze completely separately. It is also clear however, that whether they are viewed separately or together, both have much to contribute to individual and community identity and wellness. As such, they are undeniably key protective factors for at-risk communities.

OPPORTUNITIES & CHALLENGES

Six largely interrelated themes emerged from the literature review and a brief overview of the prominent research in each area was provided in the first section of this report. Each theme will now be explored with an emphasis on analysis, key issues and questions for further discussion.

1) Connection between land and health

A few research studies focused on the connection between the land and health. To examine this further it is important to explore Aboriginal concepts of the land as they relate to culture and well-being. Like many Aboriginal nations, the Anishinabek interviewed in Wilson's (2003) study refer to the land as *Shkagamik-Kwe* or "Mother Earth" (p. 88). This view of the earth is not just a metaphor or symbolic gesture; the earth is recognized literally as a feminine spirit with nurturing qualities and characteristics. Like other spirits that are part of Aboriginal cosmologies, Mother Earth is interacted with

and acknowledged through prayer, ceremony, meditation, and other daily and seasonal modes of communication.

In pre-contact times, all life forms, be they plant, animal or natural elements such as minerals and even natural phenomena like weather, were considered to be alive or to have spirits. This is clearly evidenced in Aboriginal languages, as most do not have words to describe these natural entities inanimately. When referring to an animal in the Cree language, there is no “it,” only “he/she.” The implications of these world-views can be both profound and devastating. They are profound in the sense that Aboriginal concepts allow individuals to gain a deeper sense of identity and live a life of balanced reciprocity according to traditional holistic cosmologies that still function in the modern age, thereby creating a pathway to health and wholeness. Restoring, nurturing or simply having access to these non-linear, non-western worldviews provides Aboriginal people not just a sense of identity and well-being but an alternative way of being in the contemporary world and a means to deal with some of the struggles of existing in mainstream society.

The potentially devastating implications for recognizing the earth and all plants and creatures as literally “alive” lies in the fact that enculturated individuals consciously see their sacred homelands and territories diminished through encroachment, industrial activities and other forms of western development. Across Canada, there are many stories of desecrated family and communal sites; destruction of traditional hunting, trapping and fishing sites; destruction of prime habitats and harvesting sites; and the depopulation of wildlife, food and medicinal species integral to subsistence activities. Turner (2006) provides one example of the “drastic decline” of abalone and salmon along the West Coast. In their study of Dene health perspectives, Parlee and O’Neil (2007) make a strong argument for the degradation of Dene land having direct negative impacts on various aspects of Dene health:

The rapid pace and scale of change and instability associated with mining and other kinds of large-scale resource development are also problematic and can give rise to a range of social crisis such as anomie or suicide, which Durkheim attributes to a loss of social norms and structures regulating individual behaviours (p. 114).

Aside from having to witness the irreverent destruction of living entities and Mother Earth’s bounty, traditional land-users must also cope with the powerlessness resulting from their limited abilities to minimize and mitigate government sanctioned exploitation, which is often viewed as predominately benefiting the dominant society. To

illustrate the foreign nature of these developments, most Aboriginal languages do not have words to describe the western concept natural resource, a phrase that implies that these living entities or Mother Earth’s gifts are commodities designed exclusively for the monetary benefit of humankind. This is in stark contrast with the Aboriginal view of reciprocal balance between nature, humanity and other life forms. How resource development impacts Aboriginal health is clearly an area that requires further study (Izquierdo, 2005).

2) Traditional Medicine

One of the difficulties of this theme is the use of a limited western concept to describe the holistic approaches of Aboriginal healing, as is made clear in Dr. Dawn Martin Hill’s (2003) work on traditional medicine in contemporary contexts. A vast array of methods or combination of methods from counseling, ceremony and herbal curing to shamanic guidance are used to treat specific pathologies or long-term illnesses in Aboriginal communities. Various terms related to traditional healing often mean different things to different communities. These concepts are varied, complicated and difficult to grasp through the western scientific lens (Martin Hill, 2003, pp. 5-12).

While scientific analysis might be able to determine the exact medicinal components of a specific plant, this process is often completely irrelevant to the Aboriginal process of healing and curing. From time immemorial there have always been specialists in herbal and plant medicines but even these healers used a combination of ritual and prayer, often to specific spirits. According to Cree oral tradition, not only was each plant considered alive, it might also have connected spirits that would have to be acknowledged by the healer. It was often a negotiated, reciprocal process with strict protocols to which one must adhere. A healer had to be given the “guidance” to use certain plants and it was widely recognized that this spirit power is what gave healing life to the herbs being utilized. This is why Elders describe traditional healing as a process based largely on spiritual faith.³ Waldram et al. (2006) and Turner (2006) also acknowledge the necessity of the spiritual component of preparing, using and administering medicines and the effects these are likely to have on the efficacy of the treatment. Waldram et al. (2006) add further that this is one area that scientists cannot “test” which can lead to accusations of fraudulence, yet, there are acknowledgements from the scientific community that many indigenous medicines and practices are, in fact, effective.

One important area not yet addressed is research regarding traditional medicine and healing, including an

identification of current medicinal/ herbal practitioners, levels of activity, and the current state of retention and transference of traditional medicinal knowledge. It is a widely known fact that due to colonial impacts, those knowledge systems are not as firmly grounded as they once were. Many of the most widely recognized Elders and practitioners have died in recent years, and others have reached the age where they can no longer provide active services. Many Aboriginal communities have lost these practices altogether and now have to receive healing treatment and guidance from out-of-region practitioners, quite often from other nations. The language and cultural communication barrier between some Elders and the younger generations could be further weakening the knowledge base due to fewer people being trained as medicine people. In addition, there is a growing concern in many communities about what constitutes an Elder. Some Elders and practitioners, while not seen as charlatans, are not taken seriously because of their own unhealthy lifestyles and attitudes. These realities could lead to limited knowledge and superficial understanding due to lack of proper training which in turn leads back to questions related to authority, authenticity and exploitation. In addition, as pointed out in a paper by the National Aboriginal Health Organization (NAHO) (2008) with wider recognition of the benefits of traditional medicine comes greater risks of exploitation and appropriation of tribal knowledge. Therefore, protective mechanisms would also need to be put in place.

All of these factors illustrate a need for a nation-wide dialogue, or think-tank process, to assess the overall state of knowledge, retention and transference. This would allow for an effective nation wide strategy. Researchers will also need to be aware of cultural adaptations and the increasing incorporation of western biomedicines and practices with traditional healing, as these phenomena will likely increasingly give rise to continuous issues and debates.

3) Spirituality as a Protective Factor

New seekers and students of Aboriginal spirituality are bound to be confused by the various concepts and definitions of “traditional” spirituality. Because of the devastating colonial impacts and policies, many pre-contact indigenous beliefs and ceremonies survived only in small pockets. Much of the spiritual/cultural renaissance evident throughout North America today is actually a mixture of some pre-contact practices, combined with newer “pan-Indian” ceremonies popularized through decades of intertribal sharing and borrowing. It is not uncommon to see an Arapaho ceremony in a Métis community or to partake in a Lakota ceremony in Secwepemc territory.

Some communities have also incorporated western religious influences into their spiritual practices. Many concepts such as the Medicine Wheel, Sweat Lodge, and the Pipe ceremony, originating on the prairies, spread quickly throughout the continent and today are used extensively as teaching tools and healing methods in many communities, often with varying degrees of success. The Aboriginal addictions recovery field, in particular, has been very successful at incorporating traditional ceremonies and cultured teachings with western therapeutic approaches for several generations.

It is questionable whether the full spectrum of pre-contact belief systems can ever be fully and accurately revived but one factor that would be key in attempting such a process is Aboriginal languages. Languages are the window to the soul of a culture and much can be determined about traditional worldviews and value systems through careful analysis and study of words, concepts, phrases, omissions, and comparisons with western languages and views. Does an indigenous word for “sky,” when it’s translated literally really mean just the noun sky or does this word reveal something deeper, with more profound cosmological and mythical connections? Why do many indigenous languages have no words for time, resource, economics, or please and thank-you? The only way to answer these kinds of questions is to decipher original indigenous terms from newer post-contact words that have been incorporated since contact, and research their original and literal meanings. In doing so, the spiritual nature, along with core traditional beliefs are revealed. Core spirituality can never be fully understood without an understanding of the language. This process is not possible unless a language is relatively intact. Since many of the studies examined in this paper indicate that culture, and therefore language, leads to stronger identities and wellness, language revitalization must also be considered in Aboriginal health research and health promotion initiatives.

Another aspect to consider about spirituality is that it is often the entry point to cultural rediscovery. Aboriginal spirituality is highly relational and this is one of the reasons that it is considered to be healing by the people who practice it. The community that is created by shared spiritual practices, shared expression and support, is part of why spirituality is a protective factor against health risks.

One factor that is not highlighted in many of the studies, are descriptions of specific traditional spiritual teachings. A common belief and practice amongst Elders and traditional spiritual practitioners is the showing of respect to the spirit world by reinforcing the private and personal nature of sacred teachings. Often, sacred

teachings are meant only for the individuals present within a ceremony who have made offerings to ask for advice, and subsequently recording devices like cameras or audio-equipment are forbidden. It is likely that these sacred teachings, in and of themselves, are significant deterrents to problems like suicide and substance misuse. Spiritual counsel including one-on-one and group time with an Elder or healer is an important aspect of most ceremonies and alcohol treatment centre programs, so these teachings should not be overlooked as protective factors. There are many cultural teachings that strongly dissuade suicide and describe it as a foreign concept, much the same way that some Elders describe alcohol misuse and family violence as “non-traditional.” Some healers might even interpret these health and social ills through the concept of “bad medicine” while others will utilize sacred stories or what the Cree call *âtayohkanak* as tools of counsel and guidance.

In an intertribal mobile age it is inevitable that, like ceremonies, some of these teachings and forms of spiritual counsel may not be traditional in the purest sense but likely stem from the pan-Indian movement which started in the 1970's and has evolved into the new renaissance or rediscovery movement of today. These teachings might simply be modernized versions of old teachings to suit contemporary life, teachings from another nation, or even teachings from other traditions. Culture is, after-all, an adaptable and ever-changing process and not something that remains static or stuck in the past. Anyone doing research in the area of indigenous spirituality needs to be aware of these intra-cultural changes that have occurred and continue to occur. At this time, what we know is that Aboriginal spiritual community and spiritual teachings appear to be working as protective factors, with or without analysis of the origins of specific teachings.

4) Traditional Foods

There is no doubt that Elders from various regions of Canada that still subsist on traditional country food diets have a great distrust of store-bought processed foods. This may be justified by the common fact that many processed foods are void of nutrition and contain harmful chemicals such as dyes, preservatives and artificial flavourings. Even non-processed foods like dairy products and meat contain antibiotics and hormones, and most produce contain varieties of pesticides.

Store bought meat is not good for people—that is why they get cancer. In the olden days, my husband's grandfather developed a hole in his throat from eating

non-traditional food (Judith Catholique quoted in Parlee & O'Neil, 2007, p. 124).

With recent rises in diabetes, obesity, cardiovascular illnesses, and cancer in Aboriginal communities, ailments that most Elders did not see as rampant in their younger lives, it is easy to see why contemporary foods, along with other environmental impacts, are seen as the culprits. Alternatively, most traditional foods are natural unprocessed foods that are often high in nutrition. Wild game meats such as caribou are much higher in iron than pork. Moose and deer meats are also lower in fat and higher in protein than beef, while containing no antibiotics or hormones. Fish and marine mammals contain an abundance of high quality omega-3 fatty acids. A reviewed study identified a number of advantages to traditional subsistence diets and lifestyles:

Traditional diet and lifestyle patterns provide protection against Western diseases, as rates of chronic, degenerative disease were historically very low in indigenous populations (Milburn, 2004, p. 415).

Another advantage of traditional foods is affordability. Many urban and rural Aboriginals live at or below the poverty line and are forced to shop for low-end commercial foods like processed meats, along with canned and packaged foods. Even with the increased cost of fuel and the usual costs of ammunition and supplies, it is still more economical to harvest a wild ungulate than to purchase two full sides of beef, providing one has reasonable access to a hunting area.

Other benefits pointed out in the literature include the Aboriginal concept of food as medicine, the holistic healing properties associated with being out on the land, partaking in preparations, ceremonies, and all other aspects of the subsistence harvest. Wolsko et al. (2006) report that a “subsistence lifestyle is at the core of wellness for Yup'ik people” (p. 353) and “the women remained almost entirely focused on the importance of harvesting traditional food and medicine” (p. 353). Like many other aspects of Aboriginal culture, food is also viewed in a holistic manner and it is very much related to health and spiritual well-being.

One of the challenges of studies that supported traditional food diets and subsistence lifestyles is their failure to address the current realities and limitations of subsistence lifestyles and feasibility factors such as flora and fauna depopulation, contaminants in country foods and general access to harvesting. The Haida Gwaii Diabetes project provides one example where they experimented with a monitored traditional diet to measure the effects

on diabetes, but reports the study was hindered by the limited availability of the traditional foods recommended (Heffernan et al., 1999). With traditional harvesters in many northern communities having increased difficulties due to encroachment and industrial activities, the reality of how other communities could possibly strive towards subsistence on a sustainable basis is questionable. With contaminant levels on the rise throughout the world and increasing levels of mercury and other toxins found in wild fish and game (Provincial Health Officer, 2002), solutions must be found for how communities could continue practicing subsistence or even semi-subsistence lifestyles. Finally, not only are more studies needed to determine the long-term effects of contaminants on Aboriginal country foods, but also studies that include urban Aboriginal subsistence activities. Many First Nation reserves border large city limits and they, along with other urban Aboriginals, often practice forms of seasonal subsistence activities that should not be overlooked by researchers.

5) Traditional Activities

If it is true that Aboriginal cultures are evolving and not static or set in time, it would logically follow that traditions and traditional activities also change or adjust over time. Traditional activities vary drastically from community to community. Many Aboriginal communities have evolved their own expressions of visual and performing arts and others have their own hybrid styles of music that combine traditional and contemporary influences. Hence, in Aboriginal communities across Canada, the fiddle and jigging are popular in the north and on the prairies; rodeos in Alberta and the B.C. Interior; basketball in Northwestern BC, and soccer on Vancouver Island. Because these activities have evolved into their own Aboriginal styles and within Aboriginal communities, it can be argued that they, like more standard cultural pursuits, are also traditional activities. Communities need to define for themselves what culture is and how it can be used positively to promote health amongst their people.

'Fine Arts' is another area that is easy to overlook as a protective contributor because contemporized art-forms are sometimes not seen as traditional activities. Because of social connotations and stigmas attached to concepts like "native crafts" and "folk art," the therapeutic benefit of art creation is easy to overlook for non-artists.

Most Aboriginal languages do not have specific words for the western concept of "art." However, there were many concepts to describe beauty or the creation of things in a beautiful manner and even the living of life in a beautiful

manner. Living life in a harmonious manner was something strived for by many Aboriginal communities. Just as the Anishinabe refer to this as *mino bimaatiziwin*—the good life, and the Navajo refer to it as "walking in beauty," many others today refer to this artful living in balance as "walking the red road." There were and are many opportunities and forums of creative expression which are highly valued such as sacred coastal mask dances, pow-wows, canoe carving, beading, storytelling, and oratory. Without many words for "art" there are certainly many creative art forms and expressions throughout all Aboriginal nations.

Aboriginal healing rituals and ceremonies are filled with forms of creative expression that are very healing. It is a common Aboriginal belief that the sharing of one's creative expression is akin to exposing one's soul. It is a way to honour the observers, break barriers and build communities. Like art forms in all cultures, they can also encourage and inspire others. "Through her poetry, we share ourselves, our hearts, [and] our spirits" (Celina Quock in Kenny, 1998, p. 79). Traditional artistic expressions were historically considered important forms of healing. Their continued importance as protective factors for Aboriginal people and communities at risk cannot be overlooked.

The vast number of studies reviewed, on the whole, indicate that traditional activities are protective factors against certain ailments like alcoholism, depression, suicide, and even as a buffer against the effects of racial discrimination. Unfortunately, most of these studies excluded the urban Aboriginal perspective. There is room to explore factors related to this group's access to traditional activities in relation to their health, for many urban Aboriginal communities are just as susceptible to a number of social ills. Perhaps they are even more at risk than many rural communities because of fewer opportunities to access traditions and the land required for certain activities.

6) Language

Due to the common belief that culture is language, many traditionalists and language activists argue that language acquisition is an essential part of a rich and genuine Aboriginal identity. Since there are now many Aboriginal leaders, healing practitioners, pipe carriers, and even Elders who are not fluent, language does not appear to be a requirement for enculturation.

Some of the strong arguments that can be made for Aboriginal languages, however, are quite practical. First of all, language is a living history and cultural institution that if not preserved and practiced, like anything else, will die. Language is the link that connects us to our past and

therefore to our core Aboriginal values and world-views. In this sense, it can be compared to the importance of the Bible to Christians. Without intact languages, cultures are bound to eventually become absorbed and acculturated by more dominant societies. Once a language is gone, all of that traditional knowledge accumulated for thousands of years—all those mythologies, cosmologies, ceremonies, and unique ways of viewing and interacting with the world—are gone forever.

Even though today there are Aboriginal non-speakers who are considered to be enculturated because of their lineages, knowledge bases, lifestyles, or other factors, it is doubtful that this would be possible in the future if language loss becomes a reality. Second, learning a language, even to the level of basic proficiency can provide a form of cultural immersion that accelerates and enhances the enculturation process and allows for more direct and meaningful insights of core values, traditions and beliefs. In other words, learning a language is essentially a way of getting intimate with the soul of a culture. Finally, since there are only a few studies in the area of language as a protective factor (Hallett et al., 2007; Whitbeck et al., 2004) more empirical studies are needed.

FUTURE RESEARCH

As convincing as the existing studies and all non-academic supporting literature is on the positive influence of culture on health, much room remains for new and innovative studies to be completed. As Wilson (2003) illustrates “few studies have attempted to explore the influence of cultural beliefs and values on health—let alone the intricate links between the land and health” (p. 83).

A general weakness of studies that focus on rural communities is that they ignore the issues of urban populations and transmigration. With an estimated 54 per cent⁴ of Aboriginal populations’ living in urban centres (Statistics Canada, 2008), the land-use and cultural implications for this sector of the population must be considered. Questions such as, “How do urban Aboriginal communities utilize language and culture as protective factors?” need to be addressed.

In the area of traditional foods, even though the Centre for Indigenous People’s Nutrition and Environment (2008) appears to be doing solid work in communities, they have identified the need for more research on the wide-scale long-term effects of contaminants on the food-chain and on human health. This paper supports the need for more studies in any regions that subsistence activities continue to take place. Furthermore, the growing interest in combining

aspects of western biomedicine and health approaches with Aboriginal healing also needs further study.

Current studies on language are very limited but the few that are available seem quite promising. As this is the area that has the least research completed, it needs the most attention, particularly because of language’s connection to culture. Since many communities, particularly in B.C., are in a state of archiving and reclaiming their languages, it can be quite difficult to study in terms of protective factors. A better strategy might be to focus initial studies on any of the non-endangered Aboriginal languages. It may be that historic studies focusing on indigenous language use in relation to health and spiritual well-being would be the most useful.

Due to the many factors related to both modernization and the pan-Indian and revitalization movements, and the increased urbanization of Aboriginal populations, it is very important to examine issues of cultural orientation and biculturalism as they relate to esteem and identity. These kinds of issues need to be addressed by researchers as well as communities.

Other possible areas of study are exploring the link between health and “place” as referred to by Wilson (2003) in her work on therapeutic landscapes. It is clear that Aboriginal cultures are inseparable from the land and land-based activities. The link between decimation of traditional lands and the psychological impacts on Aboriginal people needs to be more thoroughly researched.

Lastly, a further examination into the broadening of the terms cultural capital and/or linguistic capital, may be a very useful exercise for Indigenous people. Taking up this term would lend strength to the argument that indigenous cultures have worth, are worth saving and contribute in tangible ways to the health of Indigenous people. This would then add legitimacy to recognition for community-wide traditional language and cultural knowledge transference leading to the strengthening of educational and health outcomes for Indigenous people. For these reasons, appropriating the term “cultural capital” to capture the phenomena of the repository of wealth which exists in communities in the form of indigenous language, cultural knowledge, practices, and traditions is worth considering. The existence and practice of these elements of indigenous community life provide what Healy (2006) calls “cultural resilience” defined as the capacity to absorb disturbance and reorganization in order to retain key elements of structure and identity, ultimately contributing to its distinctness. Further research into the usage of these terms would expand the scholarship in the area of resilience through recognition for indigenous linguistic and cultural knowledge.

CONCLUSIONS

The evidence is mounting for the argument that Aboriginal cultures and languages contribute positively to health and wellness and therefore are protective factors against risk. The foundational studies reviewed certainly indicate this is the case but further studies are needed to strengthen these arguments and to diversify them. In future efforts towards research in this area, it is important to also keep language and culture in mind as preventative measures. Indeed, studies focusing not just on culture as treatment but also on prevention would be useful and beneficial to many communities and individuals as it is currently a neglected area.

The primary shortcoming of literature reviewed was the failure to address urban Aboriginal perspectives. In the areas of traditional land-use and cultural activities, a wide range of urbanization, transmigration and trans-territorial issues could be addressed. Wilson and Rosenberg (2002) point out that “[u]rban migrants face diminished levels of access to traditional activities, identity and the land, all of which can cause psychological and emotional health problems” (p. 2025).

As studies focusing on language as a protective factor are limited, more studies that specifically examine the various health benefits of language are desperately needed. Many community leaders are currently focused on nation-building and economic development. While these are important, the importance of promoting and supporting indigenous languages cannot be overstated. Community leaders have the power to create policies and implement change at a community level that would have far-reaching effects in sparking a turn around of language use in their community. Initiatives such as community signage in their language, making personal commitments as leaders to learn the language, and requiring staff to use greetings in their language within outgoing messages are small, inexpensive and innocuous changes that would be very simple to implement. In addition, federal and provincial governments have a responsibility to assist with language and cultural revitalization. The federal government in particular has been responsible for the era of Residential Schools in Canada that almost single-handedly wiped out indigenous languages within a few generations in addition to other aspects of colonization. Communities and individuals themselves must have an active role in hands-on learning as desire cannot be manufactured from the “outside.” Furthermore, it is necessary that all future studies employ culturally relevant, wholistic

approaches that recognize Aboriginal concepts of health.

[A] decidedly Euro-American world-view still tends to dominate the academic dialogue on conceptions of health and wellness. This is due in large part to the lack of published research describing alternative conceptions of health and wellness (Wolsko et al., 2006, p. 360).

An important consideration for researchers and practitioners is the treatment of culture and enculturation as comprehensive panaceas to all health and social ills. Clearly there are cases of individuals who are deeply enculturated, fluent in their language, and who participate in traditional activities, and still suffer from mental health issues, addictions and various other social problems. There are also some families suffering from intergenerational traumas and disorders to which no easy solutions exist. In their studies, researchers should not automatically assume that these situations are due to the failure of culture. It is unrealistic to expect traditional activities and other aspects of culture to be able to solve all health problems and issues.

RECOMMENDATIONS

A few general and specific recommendations have been made at the end of each section as well as in the future research and conclusion sections of this report. The following suggestions are ideas that arose from reviewing and discussing the literature. They are related to Aboriginal cultural and health issues but serve only indirectly as protective factors.

1) Modernization and Subsistence lifestyles

As previously pointed out, in the face of large-scale cumulative industrial impacts, a growing Aboriginal population, dwindling fish and wildlife populations, global warming and modernization factors, and the feasibility of subsistence activities for rural and urban populations needs to be explored, along with options and strategies for accessing traditional resources in a sustainable manner.

2) Urban transmigration

Issues such as urbanite use of lands for traditional pursuits, seasonal migrations to rural homelands, and use and adoption of other territories need to be addressed.

3) Getting serious about language revitalization

The Aboriginal Languages Initiative (ALI) provides funding for language revitalization that is divided between provinces. Although this has been a positive start, the funding levels

are woefully inadequate for the type of major repair needed to truly and meaningfully revitalize Aboriginal languages. In addition to increasing funding levels and creating a national language organization, Canada needs to award official language status to indigenous languages and recognize that they are the founding languages of the nation. Society is now largely aware of the impacts that Residential Schools and other colonization tactics have had on Aboriginal languages and cultures, but there continues to be many modern-day social, economic, political, and even technological pressures to give up our languages. Statistics Canada bases its evaluation on the health of an Aboriginal language on the number of speakers, however, new research states that the number of speakers alone is a poor measurement of the health of a language and rather what is most important is the occurrence of intergenerational transmission and especially how many children are learning the language (Barrena et al., 2007; Norris & Jantzen, 2002). The implication here is that even the purported healthy languages of Cree, Anishnaabe and Inuktitut could be at risk if their younger populations are no longer using their ancestral language. All levels of government from First Nations to federal, need to start recognizing this as a crisis and take action on the work that has already been started. The Royal Commission on Aboriginal Peoples (1996) and the Task Force on Aboriginal Languages and Cultures (2005) outline many recommendations that if followed, could solve many problems and provide the means for real revitalization. Communities and their leaders need to place greater priority on revitalization and seek innovative tools and strategies such as immersion programs, bi-cultural schooling, language-nests, and cost-effective strategies that are intergenerational and highly participatory, bringing language learning out of the classrooms and into communities. Finally, in recognizing the critical state of Aboriginal languages, community language authorities and leaders need to show a willingness to standardize spoken and written language when necessary, and to update, fine-tune and modernize on an on-going basis. These efforts will make more efficient use of scarce resources, create working partnerships, allow our leaders to conduct business in our own languages and capture the attention of our youth. It is dialogue, assessment, coordination efforts, and information sharing that will enable these processes and the creation of a national language organization is essential to succeed.

4) Cultural protection strategies

With many Aboriginal leaders now pushing for economic development—as a primary way to alleviate poverty and unemployment and as a necessary step towards self-

government—how can such needs be balanced within a cultural framework? If culture is a protective factor, how can economic and resource development occur in a way that protects culture, language and health? Various levels of Aboriginal and non-Aboriginal governments need to explore and address these issues if they are serious about protecting culture and promoting health. Unfortunately, the western emphasis on unbridled economic growth and personal accumulation appears also to be quickly becoming the norm in many Aboriginal communities. There are, however, a number of communities that continue to explore more culturally congruent models such as holistic, community-based economic development, the creation of local economies, and environmentally sustainable approaches to resource management. Aboriginal Tourism British Columbia (www.aboriginalbc.com) lists a number of Aboriginal-owned cultural tourism operations that seek to educate and enhance local environments rather than simply exploit them. Those balanced, community-centered approaches to economic development need to be encouraged in Aboriginal communities over some of the economic development funding programs that are based purely on western capitalist frameworks or “business as usual” approaches. It is the community economic development models that could provide a balance between health, social and economic concerns. Governments need to start designing their funding programs accordingly and stop pressuring communities into processes that guarantee resource extraction with no examination of the cumulative industrial impacts within specific regions.

5) Intertribal dialogues and cultural strategies

Frontline community-level cultural practitioners, such as language teachers, Elders, ceremonial leaders, and traditional healers rarely get opportunities to dialogue, information share, evaluate, and develop cultural plans and strategies. With so many communities immersed in negotiations and facing financial struggles, these types of initiatives often fall by the wayside. With the current state of many languages, some community organizations or government bodies need to lead the way and generate this needed dialogue. Traditional medicines and healing, along with language, stand out as key areas that need national-level strategies. It would make sense that NAHO be one of the key organizations, at least initially, to begin the process of national dialogue on traditional medicines and healing. A brief discussion paper and questionnaire sent out to Aboriginal communities’ tribal councils and regional health and cultural organizations would determine the level of interest and provide the impetus for raising the

funds required to embark on this major process. Based on feedback from organizations, the process may be a series of regional gatherings or interviews and discussions with key practitioners. It might also become a national conference with the potential for it to become an annual event. A similar nation-wide dialogue on Aboriginal languages involving information-sharing, best practices, and strategy building is also needed. With the recent federal apology on impacts related to Residential Schools, it may be an opportune time for Aboriginal organizations to pressure federal and provincial governments to provide more substantive funding for Aboriginal language development. For national-level language initiatives, however, there is currently no organizational body to administer such processes. The Task Force on Aboriginal Languages and Cultures, consisting of nation-wide representation, have already made recommendations to the Department of Canadian Heritage for the establishment of a national Aboriginal language organization, and this recommendation appears to have had grassroots support. The report, *Towards A New Beginning*, offers valuable recommendations, including establishing an interim body made up of the Task Force members to create a framework for a national organization (Task Force on Aboriginal Languages and Cultures, 2005). The Assembly of First Nations and other Aboriginal lobby groups need to pressure the government to follow up on the language recommendations made in both the RCAP final report and the executive summary of the report by the Task Force. A national language organization is desperately needed and long overdue.

CLOSING REMARKS

The Public Health Agency of Canada now considers culture among the key determinants of health (National Aboriginal Health Organization, 2008; Public Health Agency of Canada, 2008). Mohawk scholar Taiaiake Alfred (2004) writes, "the core of our existence as nations is in our traditional cultures" (p. 95). Time and time again, Aboriginal people assert that language is the foundation for culture and without our languages, our cultures cannot survive (Battiste, 1998; Kirkness, 1998; Kirkness, 2002). The Assembly of First Nations (2007) conducted a longitudinal survey of First Nations health and concludes in chapter two of the report that language and culture are part of the overall well-being of both individuals and communities/nations. Clearly the time to take action is now - as individuals, and to also make this demand of our community leaders, as well as elected officials, in order to revive and hold high the indigenous cultures of this land, if for no other reason than for the

tremendous effect and potential they hold for the renewed and continued wholistic health of Indigenous people.

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END NOTES

1. The term 'language families' is a linguistics term used to categorize languages that are linguistically related but generally unintelligible to one another (unlike dialects).
2. Adapted from (Maracle, 1999; Simpson, 2001; White, 1988; Wilson, 2003; University of Manitoba, 2008) and author's definition.
3. This information is based on the author's (Napoleon) 15 years of training under the guidance of Cree Elders and spiritual healers.
4. Author's note – Many Aboriginal leaders believe this number is inflated due to the inclusion of urban reserves and members temporarily away for school or employment.

Traditional Medicine and Restoration of Wellness Strategies

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ABSTRACT

The overview of literature provides emergent themes on the topic of Aboriginal health, culturally oriented interventions and prevention strategies. Recommendations are also provided on how to apply indigenous knowledge and traditional medicine approaches in the intervention for at risk Aboriginal populations or communities in crisis. Through a literature review of indigenous knowledge, it is proposed by several Indigenous scholars that the wellness of an Aboriginal community can only be adequately measured from within an indigenous knowledge framework which is a holistic and inclusive approach that seeks balance between the spiritual, emotional, physical, and social spheres of life. Their findings indicate that high rates of social problems, demoralization, depression, substance abuse, and suicide are prevalent in many Aboriginal communities and must be contextualized within a decolonization or self-determination model. The evidence of linkages between the poor mental health of Aboriginal peoples and the history of colonialism is key to improving the wellness in communities. Conversely, there is sufficient evidence that strengthening cultural identity, community integration, and political empowerment contributes to improvement of mental health in Aboriginal populations including at risk youth and women. The interconnection of land, language and culture are the foundations of wellness strategies. The overview clearly suggests adopting new strategies for intervention and prevention, and learning from historical wrongs to ensure future policies support of the restoration of traditional practices, language and knowledge as a means of developing strategies for this generation's healing and wellness.

KEYWORDS

Traditional medicine and healing, Indigenous knowledge, intervention and prevention, historical trauma, holistic and inclusive approaches, partnerships of empowerment in restoration of culture and wellness strategies

INTRODUCTION

This paper will review literature on the topic of traditional medicine and indigenous knowledge as protective factors for at risk Aboriginal populations and communities. Aboriginal peoples will be used to define First Nations, Métis and Inuit peoples of Canada. According to the National Aboriginal Health Organization, Aboriginal peoples in Canada are identified in the following ways:

ABORIGINAL PEOPLES: Is a collective name for all of the original peoples of Canada and their descendants. Section

35 of the Constitution Act of 1982 specifies that the Aboriginal Peoples in Canada consist of three groups – Indian (First Nations), Inuit and Métis. It should not be used to describe only one or two of the groups.

ABORIGINAL PEOPLE: When referring to Aboriginal people with a lower case people, you are simply referring to more than one Aboriginal person rather than the collective group of Aboriginal Peoples. (NAHO, 2007, p. 32).

The following discussion will outline the basic tenants of

indigenous knowledge, traditional knowledge, medicine, and healing as preventative factors for Aboriginal communities. The overview provides emergent themes of literature on the topic of Aboriginal health, culturally oriented interventions and prevention strategies. Recommendations are also provided on how to apply indigenous knowledge and traditional medicine approaches in the intervention for at risk Aboriginal populations or communities in crisis.

DEFINING TRADITIONAL MEDICINE

Traditional medicine and healing are difficult concepts to define, as many Aboriginal peoples describe the medicine and practices within the localized geographical context of their community or nation. However, working definitions are provided by the World Health Organization (WHO) and the Royal Commission on Aboriginal Peoples (RCAP). The term “traditional medicine,” as defined by WHO:

Is the sum total of knowledge, skills, and practices based on the theories, beliefs, and experiences Indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement of treatment of physical and mental illness (WHO, 2001).

The *Report of the Royal Commission on Aboriginal Peoples* (1996) defines *traditional healing* as:

Practices designed to promote mental, physical and spiritual well-being that are based on beliefs which go back to the time before the spread of western ‘scientific’ bio-medicine. When Aboriginal Peoples in Canada talk about traditional healing, they include a wide range of activities, from physical cures using herbal medicines and other remedies, to the promotion of psychological and spiritual well-being using ceremony, counseling and the accumulated wisdom of elders (RCAP, 1996, Vol.3, p. 348).

The terms *Elder* and *healer* are used interchangeably since traditional teachings are considered “healing for the mind.” “Elder” is another term attached to traditional healing that is discussed in the Gathering Strength Volume of the *Report of the Royal Commission on Aboriginal Peoples*. The report states that Elders are “Keepers of tradition, guardians of culture, the wise people, the teachers. While most of those who are wise in traditional ways are old, not all old people are Elders, and not all Elders are old” (ibid).

Through a literature review of indigenous knowledge, it is proposed by several Indigenous scholars that the wellness of an Aboriginal community can only be adequately measured from within an indigenous knowledge framework which is a holistic and inclusive approach that seeks balance between the spiritual, emotional, physical, and social spheres of life (Stewart, 2007; Martin-Hill, 2003; Kelm, 1998; Duran & Duran, 1995). Martin-Hill (2003) suggests Elders and healers frequently frame western concepts as disconnected from culture, families and community. Several Elders interviewed in Martin-Hill’s (2003) research found that traditional medicine and knowledge are not to be isolated from a way of life; it’s all encompassing of diet, physical, spiritual, and emotional thoughts and actions. Healing is one aspect, and as stated, “a smile or words of encouragement” can be good medicine (workshop interviews, 2002; ibid). As such, the Elders address intervention and prevention with an emphasis on lifestyle not curative ceremony. Data gathered by the First Nations and Inuit Regional Health Survey (RHS) in 2002 presented progress amongst Aboriginal communities in the areas of community well-being by integrating traditional activities including those used to enhance self-esteem. It is the position of this analysis that only through an integrated approach to community health services that supporting traditional medicine and practices within culturally sensitive environments will the current state of crisis within Aboriginal communities find remedy. This includes promoting culture and self-esteem among Aboriginal peoples and their communities (RHS, 2002).

The assumptions presented by Aboriginal traditional world-views have been articulated by several scholars as fundamental for framing a system of knowledge that is valid and based on sound science. Currently, there are emerging discourses that explain and define traditional thought as a part of indigenous knowledge.

INDIGENOUS KNOWLEDGE

Dr. Daes (1993), *Report on the Protection of Heritage of Indigenous People* (as cited in Battiste & Henderson, 2000) states:

Indigenous knowledge is a complete knowledge system with its own concepts of epistemology, philosophy, and scientific and logical validity...which can only be understood by means of pedagogy traditionally employed by these people themselves (p. 44).

According to Marlene Brant-Castellano's article in Dei, Hall and Rosenberg's (2000) *Indigenous Knowledge's in Global Contexts*, indigenous knowledge has a multiplicity of sources including:

Traditional – passed on through generations through oral stories, histories and inter-action with the environment.

Empirical – observations made over time and incorporated into ecological knowledge.

Spiritual – revelation understood through dreams, visions or even as divine messengers.

Vandana Shiva (2000) states that indigenous knowledge is a pluralistic system that has been delegitimized by western science. She writes:

Indigenous Knowledge's have been systematically usurped and then destroyed in their own cultures. Diversity and pluralism are characteristic of non-western societies. We have a rich biodiversity of plants for food and medicine. Agricultural diversity and the diversity of medicinal plants have in turn given rich plurality of knowledge systems in agriculture and medicine.

However, under the colonial influence the biological and intellectual heritage of non-western societies was devalued...transformed the plurality of knowledge systems into a hierarchy of knowledge systems. When knowledge plurality mutated into knowledge hierarchy, the horizontal ordering of diverse but equally valid systems....(p. vii).

The displacing of indigenous knowledge will be addressed in the literature overview of numerous authors examining traditional knowledge (also identified as indigenous knowledge). Before over viewing the literature on the topic of traditional knowledge and communities in crisis, a discussion of statistics and Aboriginal demography will provide insights to population trends and identify target groups providing a context for a population in crisis.

STATISTICS & DEMOGRAPHY

An Overview

Cloutier et al., (2008) write in the Statistics Canada analysis of 2006 Aboriginal census data, that according to information collected, the current socio-economic status of First Nations children is bleak. Nearly half (49 per cent) of off-reserve First Nations children under the age of six live in low-income families, compared to 18 per cent of non-Aboriginal children. While 57 per cent of young off-reserve First Nations children living in large urban cities are living in low-income families. Registered Indian status First Nations children are more likely to live in low-income families than non-status Indian children, 55 per cent and 38 per cent respectively (Statistics Canada, 2008). There has also been a growing movement of First Nations children living in urban areas, 78 per cent compared to a remaining 22 per cent living in rural areas and Aboriginal communities (Cloutier et al., 2008, p. 12).

Statistics Canada reports that in 2006 census data, the majority of Aboriginal children aged 14 and under (58 per cent) lived with both parents, while 29 per cent lived with a lone mother and 6 per cent, with a lone father, 3 per cent of Aboriginal children lived with a grandparent (with no parent present) and 4 per cent lived with another relative (Cloutier, 2008; Statistics Canada, 2008). In other words, almost half of Aboriginal children are being raised with one or less parent.

Furthermore, the current age demographics of Aboriginal Peoples in Canada illustrates an urgent need to address the despair experienced among many in Aboriginal populations and communities. The majority of the Aboriginal population is young with the median age of 27 as compared to the non-Aboriginal population which median age is 40 (Cloutier, 2008, p. 7). Among all Aboriginal people, almost one-half (48 per cent) are children and youth aged 24 and under, compared to only 31 per cent of the non-Aboriginal population. Similarly, 10 per cent of the Aboriginal population is aged five to nine, compared with only 6 per cent of the non-Aboriginal population. Based on this data, Statistics Canada reports the population projection for Aboriginal people in the next decade could account for an escalating share of the young adult population of Canada. In fact it is anticipated that by 2017 Aboriginal people in their 20's could make up approximately 30 per cent of the whole population in a similar age categories in provinces across Canada (Statistics Canada, 2008).

Literature Overview

The proceeding literature overview provides a number of articles and books that address issues facing Aboriginal populations and communities in crisis and/or address the topic of traditional knowledge, medicine and culturally relevant intervention and prevention strategies. Youth, women and mental health were frequent themes discussed in the literature. The historical colonialism, oppression, displacement, and assimilation of Aboriginal peoples and communities arises as a central factor influencing the array of social, environmental, political, and health issues impacting Aboriginal communities. A discussion of the current state of Aboriginal health and well-being cannot be complete without first examining the historic legacy of colonialism that has shaped Aboriginal life. Colonialism is identified by several authors as the source of historical oppression and the cause of the current health status of Aboriginal people.

What is colonialism and how is it directly linked to historical and current influences that determine such conditions as poverty, educational non-achievement and socio-economic status? According to sociologist James Frideres (2008), colonialism is best understood in seven parts. He outlines the key processes as synthesized into the following points:

- The incursion of the colonizing group into a geographical area.
- Colonization's destructive effect on the social and cultural structures of the indigenous group. Colonizers destroyed the people's political, economic, kinship, and in most cases religious systems.
- Interrelated processes of external political control and Aboriginal dependence, (Department of Indian and Northern Affairs Canada, 1999) is the "representative ruler" in this model of Aboriginal economic dependence.
- Colonization is the provision of low quality social services for the colonized Aboriginal people in education and health.
- Related to the social interactions between Aboriginal people and white people referred to as the color-line or racism. Racism is the belief in the genetic or cultural superiority of the colonizing and the inferiority of the colonized.

- Prevention from entering into the economy – creating a "culture of poverty" - creating two economies; one for Canadians who have the skills required and one for Natives who do not.

An example of an ill informed social policy is the Children's Aid policy of adopting out Aboriginal children during the sixties. The policy known as the 60's scoop, removed over 1500 children from their homes based on Eurocentric assessments of Aboriginal families. The impact of colonialism on Aboriginal people's lives is beyond measure and has exacted a significantly terrible toll on Aboriginal families and children specifically. *A National Crime* by John Milloy (1999) reported further that the conditions Aboriginal children faced in government child care and the residential school system were deplorable due to poor nutrition, hard labour and unsanitary conditions. Furthermore, the sexual, emotional, physical, and cultural abuse in the system was widespread and severe, serving to erode the traditional knowledge, practices, identity, pride of heritage, and language of Aboriginal peoples (Milloy, 1999).

Healing Traditions: Culture, Community and Mental Health Promotion with Canadian Aboriginal Populations by Laurence Kirmayer, Carl Simpson and Margaret Cargo (2003) reviews literature examining links between the history of colonialism, government interventions and the mental health of Aboriginal Canadians. Their findings indicate that high rates of social problems, demoralization, depression, substance abuse, and suicide are prevalent in many Aboriginal communities. They suggest evidence of linkages between the poor mental health of Aboriginal peoples and the history of colonialism. Conversely, there is sufficient evidence that strengthening cultural identity, community integration, and political empowerment contributes to improvement of mental health in Aboriginal populations (Kirmayer, 2003).

Walking in a Sacred Manner, Healers, Dreamers, and Pipe Carriers- Medicine Women of the Plains Indians by Mark St. Pierre and Tilda Long Soldier (1995) explores the interconnectedness of the spiritual with the everyday life of Plains Indian culture. The Plains culture observed spiritual laws as a way of life that promoted core values of cherishing children, women and the elderly. The creation stories and spiritual laws were interrupted by missionizing and massacres which left the Plains culture in a state of grief and loss. The central thesis is that women have always played a critical role as spiritual leaders and healers and were the backbone of their societies. Throughout the colonial era, the Plains culture adopted western views of women and children

which led to a state of social disarray. Mark St. Pierre and Tilda Long Soldier (1995) suggest the need to re-instate the traditional laws to improve the quality of life for Plains people, families and communities.

In her publication entitled *Colonizing Bodies, Aboriginal Health and Healing in British Columbia 1900-50*, Mary-Ellen Kelm (1998) examines the impact of colonization on the health of Aboriginal people in British Columbia. Kelm's analysis of Aboriginal health statistical data demonstrates critical factors such as how colonization impacted traditional diets and nutrition that led to severe erosion of Aboriginal peoples' health. The under-serviced health care compounded by loss of traditional subsistence and healing practices led to the current poor health of Aboriginal people. Her linking the loss of traditional knowledge in preventative health practices to that of colonial policies that outlawed 'a way of life' is detailed with both quantitative and qualitative data. Much of the literature suggests there is a linkage between colonialism and ill-health of Aboriginal people and Kelm's in-depth analysis is evidence to the commonly held view. She also suggests that loss of autonomy over one's body is similar to the continued government practice of controlling Aboriginal peoples. Restoring traditional healing practices and knowledge is a pathway to both empowerment and healthy communities.

Aboriginal Suicidal Behavior Research; from Risk Factors to Culturally-Sensitive Interventions by Laurence Katz et al., (2006) state that: "There is a significant amount of research demonstrating the rate of completed suicide among Aboriginal populations is exceedingly higher than the general populations" (p.159). They suggest there is a shortage of research on evidence based interventions for suicidal behaviour. The results of their study suggest developing a research program that tracks intervention is a solid evidence based process to study risk factors and interventions. They conclude that identifying risk factors for Aboriginal suicidal behaviour is required to develop appropriate interventions. The multi-faceted problem of suicide requires increased knowledge of the types of culturally sensitive suicide prevention strategies identified (Katz et al., 2006, p. 165).

In his book *Fighting Firewater Fictions, Moving beyond the Disease Model of Alcoholism in First Nations* Richard Thatcher (2004) describes that traditional knowledge needs to be restored as an intervention to the addictions facing Aboriginal communities. Thatcher (2004) describes the role colonialism played in missionizing that led to spiritual bankruptcy in Aboriginal peoples and is seen as a precursor to poor coping skills with alcohol and other substances. He explains that recovery must provide Aboriginal people with the skills to heal from historical trauma.

Walters, Simoni and Evans-Campbell's (2002), *Substance use among American Indians and Alaska natives: incorporating culture in an "indigenist" stress-coping paradigm* proposes a new stress-coping model that manifests a paradigm shift in the conceptualization of health. They conclude cultural identity is part of traditional medicine and healing paradigms. Through decades of assimilation policies in Canada and the residential school suppression of Aboriginal language, drumming, singing, or spiritual practices, many have lost connection to their cultural belief systems and knowledge. Cultural identity was identified as an issue for traditional healing as many Aboriginal people have never been exposed to traditional practices and do not identify with the belief system embedded in traditional healing practices such as sweat lodges, false face healing rituals or other indigenous healing methods. These ceremonial practices would be as foreign to highly acculturated Aboriginal people as it would be to non-Aboriginals who have no context in which to decipher what is transpiring in the ceremony. However, many Aboriginal people are attempting to recover and revitalize their heritage and ceremonies as a means of healing.

Access to Traditional Medicine in a Western Canadian City, by James Waldram (1990) examined research in Saskatoon with 147 Aboriginal people and found that there were a number of factors that influenced the individuals' choice and usage of traditional medicine. Waldram identified at least six distinct Aboriginal cultural groups in Saskatoon. One group in the study had concerns over the use of "bad" medicine. One of the major differentiating characteristics between traditional medicine and biomedicine is the duality that many indigenous groups believe there is "good" and "bad" Aboriginal medicine. Respondents to the questionnaire clearly indicated that they would use a traditional healer, but the issue of "bad medicine" is a complex belief that clearly demarcates traditional medicine from western biomedicine. Also, people who have adopted a variety of spiritual beliefs, such as Pentecostalism, Catholicism and other organized religious beliefs, would not support traditional healing approaches from a spiritual/ritual perspective. Religious affiliation, however, may not be a barrier for Aboriginal people when choosing a specialized Aboriginal health service outside of the spiritual, ceremonial realm, for example, herbalism and midwifery (Waldram, 1990, pp. 325-348).

Language is also identified as an important factor in traditional knowledge and or the practice of medicine. The expert paper written for the United Nations Permanent Forum on Indigenous Issues, *Indigenous Children's Education and Indigenous Languages*, identifies language as the key success factor for educational achievement in indigenous communities. The panel concluded that:

Present-day indigenous and minority education shows the length of the mother tongue medium education is more important than any other factor (including socio-economic status) in predicating the educational success of bilingual students (UN, 2008, p. 2).

The report explains that the dominant language is often from a colonizing framework which subtracts and displaces indigenous languages rather than approaching education as a bi-lingual enterprise providing an additional language in educational repertoire. The subtractive model of education, taught to Aboriginal children, implies an inferiority of their language and culture which inhibits pride, self-esteem and empowerment (ibid).

In his book *Unfinished Dreams: Community Healing and the Reality of Unfinished Dreams*, Wayne Warry (2000) suggests that communities in crisis require a degree of self-governance and empowerment to meet their unique needs. He suggests that for communities to be successful in crisis intervention there must be a concerted effort to train them and provide them with the tools for skill enhancement. Warry (2000) also emphasizes the need for community members to develop skills that would assist them in identifying suicidal behaviour, communications and facilitation of traditional healing practices, and western specialized approaches. His analysis of services in Aboriginal communities concludes that Aboriginal self determination and the improvement of mental health services would serve to repair the current status of northern communities in crisis (ibid).

In Maria Brave Heart's (1998), *The Return to the Sacred Path: Healing the Historical Trauma and Historical Unresolved Grief Response Among the Lakota Through A Psycho Educational Group Intervention*, she integrates the concept of Post-Traumatic Stress Disorder (PTSD) and psychic trauma with traditional healing methods. Her seminal work includes acknowledging the behaviours associated with this diagnosis of historical trauma as effecting Indigenous populations. She explains historical trauma is unresolved grief and the behavioural responses are: 1) withdrawal and psychic numbing; 2) anxiety and hyper vigilance; 3) guilt; 4) identification with ancestral pain and death, and 5) chronic sadness and depression. Brave Heart's research conducted with Lakota human service providers concluded that the Lakota suffer from impaired grief of an enduring and pervasive quality.

The root cause of communities in crisis is driven by collective impaired grief that results from massive cumulative trauma associated with "such cataclysmic events as the assassination of Sitting Bull, the Wounded Knee Massacre, and the forced removal of Lakota children to

boarding schools" (Brave Heart, 1998, p. 50). Brave Heart also encourages the enhancement of training for service providers and intervention strategies that incorporate traditional healing methods to help facilitate the recovery of historical trauma. Brave Heart's (1998) work is in the same conceptual framework as mental health profiles found in the *Aboriginal Healing Foundation Research Series: Mental health profiles. British Columbia's Aboriginal survivors of the Canadian residential school system* states that:

Three-quarters of the case files (74.8 per cent) provide information about the current mental health of the subjects. Of these case files, only two indicate that the subject did not suffer a mental disorder. As expected, based on the mental health literature on residential school Survivors, the most commonly diagnosed disorder is post-traumatic stress disorder (64.2 per cent), followed by substance abuse disorder (26.3 per cent), major depression (21.1 per cent) and dysthymic disorder (20 per cent) (Corrado & Cohen, 2003, p. 68).

Mitchell and Maracle's (2005) publication *Healing the generations: Post traumatic stress and the health Status of Aboriginal populations in Canada* confirms the role of historical trauma and the need to develop a model for mental health services to Aboriginal populations. They suggest that the following criteria are necessary to develop an efficient model:

1. An acknowledgment of a socio/historical context.
2. A reframing of stress responses.
3. A focus on holistic health and cultural renewal.
4. A proven psycho-educational and therapeutic approach.
5. A communal and cultural model of grieving and healing (p. 18).

They further suggest that there are four phases for community healing which include getting a core group together to address healing needs, increasing healing activity, recognition of root causes of addictions or abuse, building capacity by providing training, and lastly, shift from fixing problems to transforming systems (Mitchell & Maracle, 2005, p. 20).

Aboriginal children and youth mental health literature entitled, *Mental Health and Well-being of Aboriginal children and Youth: Guidance for New Approaches and Services* summarize the state of Aboriginal children and youth's mental health as a consequence of the following historical and contemporary issues:

- Profound impacts of residential school experience on family functioning.
- Multi-generational losses among First Nations people.
- Emphasis on collectivist rather than individualistic perspectives education and health.
- Relevance of community-based healing initiatives (Mussell, Cardiff & White, 2004, p. 4).

Their findings offer several recommendations for long term commitment to building capacity in Aboriginal communities. The action items should:

- Recognize the role that culture plays in determining health.
- Focus on implementing ecological, community level interventions.
- Promote local leadership and develop high quality training.
- Provide mentoring and support.
- Foster links between communities.
- Support on going capacity building.

They also suggest large scale interventions are needed with regards to First Nations families, which encompass the entire ecological nature of the issue. They state that:

It is not expected that individually focused models of treatment strategies must understand that the problems facing First Nations communities are complex and involve multiple factors including individuals, families, peers, schools, community's culture, society and environmental factors. Children and youth safety, health and well-being are linked to quality interaction not only within family but across these other sectors of influence. The development of effective approaches must involve input from a wide array of sectors, organizations and individuals (Ibid, 2004, p. 19).

Furthermore, Suzanne Stewart (2007) writes that despite elevated rates of mental health issues among Aboriginal populations that contribute to overwhelming rates of suicide in Aboriginal youth, mental health services are underused by Aboriginal peoples. Lee and Armstrong (1990) explain that throughout history cultures have found methods for dealing with psychological distress and behavioural deviance. They further state that in the interest of developing awareness, knowledge and skills to promote cultural responsiveness, counseling professionals need to appreciate traditional healers. Likewise, Stewart (2007)

asserts that incorporating indigenous approaches to helping and healing are essential methods for addressing the mental health crisis in Aboriginal communities and populations. She describes indigenous models and practices of helping and healing as:

- Storytelling.
- Advise from Elders.
- Interconnectedness with family and community.
- Healing circles.
- Ceremony.

Stewart (2007) further explains that these indigenous methods and practices for helping and healing need to include the involvement of local communities, Elders and traditional helpers.

Duran and Duran's (1995) *Native American Postcolonial Psychology* observed the ways in which western constructions of mental health have had serious consequences for Native Americans. They explain:

A good example of how some of the ideology of biological determinism affects people is seen in the field of psychometric assessment. The relevant literature is filled with studies showing cultural bias and outright racist practices, yet researchers continue to use the same racist tools to evaluate the psyche of Native American peoples (p. 19).

They suggest the current tools to evaluate Aboriginal mental health do not take into consideration the colonial context or the Euro-culture based assessment methods which have not worked well for improving the mental health of Native Americans. The lesson learned is the critical need to develop culturally sensitive assessment tools and intervention strategies.

These studies exemplify the significance of culture, and community in intervention programming and community services. Their analysis also demonstrates the need to employ a multiplicity of services and for Aboriginal families and services to work together to address collective mental health needs. Another target group, Aboriginal women, has been identified as marginalized within its own community.

Lisa Udel's (2001) *Revision and Resistance, The Politics of Native Women's Motherwork* concludes that, Native women require men's social and cultural participation in tribal life in order to ensure survival of specific collective experiences and to perpetuate their traditions in their communities (p. 61). The cultural networks, both mothers and fathers enjoyed, have been diminished due

to colonialism and have resulted in Aboriginal children suffering. This is why it is urgent to move swiftly to find new ways to improve their quality of life which would include recovery of traditional practices in contemporary settings.

Traditionally, Aboriginal women were highly regarded as the mothers of our nations as they were seen as “*givers of life*” through their ability to bear children, and foster the healthy development of the future generations (Benoit & Carrol, 2001, p. 1). Similarly, Long and Curry (1998) suggests that women were the primary transmitters of wisdom and culture through oral traditions. The authority and the esteemed positions that Aboriginal women held in their societies have been severely eroded through federal policies that have disrupted women’s roles (Long & Curry, 1998).

The objective of the *Aboriginal Women’s Health Research Synthesis Project Report* states:

Our agenda is to illustrate traditional Indigenous knowledge and practices concerning traditional parenting as essential methods to improving the health and wellness of Aboriginal families. Namely by supporting First Nations in restoring women’s traditional knowledge and roles within the family, clan and community is an essential cultural healing tool (Stout, Kipling & Stout, 2001, p.12).

In the article, *Identity, Recovery, and Religious Imperialism: Native American Women in the New Age*, Cynthia Kasee (1995) asserts Aboriginal women often lack the economic means to access traditional medicine. Thus the ill health of many Aboriginal women within Aboriginal communities is often a direct result of poverty and low cultural identity, demonstrating the unequal power-relations found in communities. It is a battle for Indigenous women to access traditional healing even though their lack of wellness is greater than men’s. Aboriginal women have been both formally and informally marginalized through legal, social and economic impositions into the family and community (Kasee, 1995, p. 85).

In *A Recognition of Being* Kim Anderson (2000) states that Aboriginal women’s societal positioning and authority were undermined by missionaries and the government, influences severely impacting their economic and social autonomy. Anderson explains that the diversity in socio-cultural arrangements allowed, in both matrilineal and patrilineal cultures, gender autonomy through a women’s voice. She outlines the specific impacts of colonialism in displacing Aboriginal women from their rightful positions within their own societies. The main issues Indigenous women identify are power and domination, cultural

constructs of Aboriginal women’s identity, and knowledge which assumed the inferiority of Indigenous women. Women have taken up the issue of Indigenous women’s resistance to dominant hegemony and their constructions “of them.” The western literature had been primarily concerned with responding to legal-social policies implemented through colonialism.

In *Black eyes all of the Time; intimate Violence, Aboriginal Women, and the Justice System*, McGillivray and Comeskey (1999), suggest that the normative socialization through years of colonialism within Aboriginal communities has the effect that violence against women is no longer viewed as deviant behaviour. McGillivray and Comeskey (1999) state the rate of intimate violence against women is consistently higher than violence against men. Eight in 10 Aboriginal women witnessed or experience intimate violence in childhood, and the same number have been child or adult victims of sexual assault. Between 75 and 90 per cent of northern Ontario’s Aboriginal women are assaulted in an adult relationship. Aboriginal women typically endure 30 to 40 beatings before calling police, and physical injury is the leading cause of death of Aboriginal women on reserve. Statistical relationships between intimate violence and the death of women in geographically culturally remote populations require further investigation (McGillivray & Comeskey, 1999).

In *Aboriginal Single Mothers in Canada: An Invisible Minority*, Jeremy Hull (1996) explores the challenges facing Aboriginal mothers in Canada today. Hull overviews the statistical data of single mother’s housing and income, exposing the challenges Aboriginal women face in achieving the most basic quality of life. The ability to raise consciousness and empowerment for Aboriginal women however, is contingent on several variables including poverty, suicide and violence, which plague Aboriginal women and youth.

In *Identity Formation and Cultural Resilience in Aboriginal Communities*, Christopher Lalonde (2005) describes resilience as the ability of whole cultural groups to foster the healthy development of children and youth. In examining high suicide rates among Aboriginal communities, he found that the rates are unevenly distributed with communities that have enhanced “cultural continuity” having the lowest suicide rates. Lalonde (2005) suggests that what is needed to find solutions for improving well-being for Aboriginal youth lies with the communities, lateral knowledge exchange efforts, and cross-community sharing of indigenous knowledge. Furthermore, Lalonde (2005) asserts that success in improving the status of First Nations communities lies in efforts to restore cultural sovereignty to expand the indigenous knowledge that has allowed First Nations peoples to overcome historical and present adversities.

DISCUSSION

The Impact of Colonialism on Communities & Emerging Factors

Inter-generational trauma is exacerbated by the ongoing colonial framework Aboriginal people have to struggle with. The Royal Commission on Aboriginal Peoples (1996) emphasizes the need to contextualize Aboriginal health within a historical framework of colonialism. Research by Kirmayer, Simpson and Cargo (2003) found that high rates of social problems, demoralization, depression, substance abuse, and suicide are prevalent in most Aboriginal communities. They suggest there is evidence of linkages between the poor mental health of Aboriginal peoples with the history of colonialism and oppression. Mary-Ellen Kelm's (1998) Aboriginal health statistical data analysis demonstrates how colonization impacted traditional Aboriginal people's health. Kelm links the loss of traditional knowledge of health practices to colonial policies that outlawed 'a way of life' and suggests there is a linkage between colonialism and ill-health of Aboriginal people. Richard Thatcher (2004) explains that colonialism played a significant role in destroying this knowledge through colonialism, and that missionizing has led to spiritual bankruptcy, leading in turn to alcohol and other substance addictions among Aboriginal populations and communities. Likewise, Voyle and Simmons (1999) write that the "... alienation and marginalization within their own countries have had deleterious consequences for [Aboriginal] cultural traditions and identity, social cohesion and self-esteem" (p. 1035).

Authors Mark St. Pierre and Tilda Long Soldier (1995) write that the creation stories and spiritual laws of Aboriginal peoples were interrupted by missionizing and massacres which left Aboriginal culture in a state of grief and loss. The authors state that Aboriginal women have always played a critical role as spiritual leaders and healers and were the backbone of their societies. However, through the colonial era, Aboriginal culture adopted western views of women and children which led to a state of social disarray (St. Pierre & Long Soldier, 1995). There is no doubt colonialism has had both direct and indirect negative consequences for Indigenous people's health.

According to Fournier and Crey (1997), "[A]boriginal children were taken away in hugely disproportionate numbers less for reasons of poverty, family dysfunction or rapid social change than to effect a continuation of the colonial argument" (p. 85). They further state that in the East side of Vancouver, social workers had noted that most Aboriginal people living in the depths of addictions,

sex trade and extreme poverty are graduates of residential schools and the sixties scoop. There are Aboriginal communities in crisis that do not have access to their traditional practices, knowledge and culture, leaving the sense that assimilation policy has achieved its goal (ibid). The historical policies that attempted to assist Aboriginal people have failed miserably, creating social chaos and alienation of Aboriginal people from dominant society and their own heritage. The overview clearly suggests adopting new strategies for intervention and prevention, and learning from historical wrongs to ensure future policies support the restoration of traditional practices, language and knowledge as a means of developing strategies for this generation's healing and wellness.

Factor: Colonialism as the Root Cause of Communities in Crisis:

Literature on the state of Aboriginal communities' health and health care services confirm the need for Aboriginal community control over health care, which must include access to traditional medicine as a critical aspect to community well-being and health. The recognition of the validity and importance of traditional medicine within the mainstream health care system is also a key component to improving the status of Aboriginal health. There was a general consensus that throughout history, Eurocentric education curriculums and residential schools regarded indigenous knowledge as unscientific and superstitious. Further, the consensus among anthropologists is that indigenous knowledge of medicine has suffered even greater stigmatization through missionaries, through assimilation policies that successfully outlawed ceremonies from being practiced, and even jailed many political and spiritual leaders up until the mid-1900s (Cummins & Steckley, 2000).

Factor: Education as a Tool for Assimilation:

The legacy of education within Aboriginal communities is not a positive one. In light of this historical context it is easy to understand why education was and is still viewed as a place where one is disempowered, not liberated. Education is not viewed as a tool for liberation and success which may explain the poor retention rates of Aboriginal people in the education systems. According to a world panel for the U.N., *Indigenous Children's Education and Indigenous Languages* expert paper written for the United Nations Permanent Forum on Indigenous Issues:

They learn a dominant language at the cost of their mother tongue which is displaced, and later often replaced by the dominant language. Subtractive

teaching subtracts from the child's linguistic repertoire, instead of adding to it. Research conclusion about the results of present-day indigenous and minority education show the length of the mother tongue medium education is more important than any other factor (including socio-economic status) in predicating the educational success of bilingual students (UN, 2008, pp. 2-3).

Factor: The Loss of Value and Support for Woman:

Women were impacted by the dominant society's historical views of women's place in society. The erosion of their traditional positions of value was significant and unique to their gender. Few people have the experience of having their children removed to attend residential schools and later to experience the sixties scoop. It was stated that the sixties scoop, the removal of children en-mass from their families, was due to 'poor living conditions'. Children were removed by the Children's Aid Society because their assessments were based on western constructs of child care and welfare. The 15,000 children removed were taken out of state and country and the families had no recourse to have their children returned (Steckly & Cummins, 2000; Fournier & Crey, 1997).

The continued assault on Aboriginal people's culture and heritage had inter-generational impacts on societal mores and ethos. People were demoralized in childhood by the education system and further harmed through authority figures and the dominant society. The outcomes of such experiences are embedded in current statistics showing a number of social ills. The state of Aboriginal women in Canada is another indicator of families in crisis. Current statistics reveal Aboriginal women have a higher chance of incarceration. RCAP's (1996) report states:

The imposition of the Indian Act over the last 120 years, for example, is viewed by many First Nations women as immensely destructive. Residential schools and relocations subjected Aboriginal communities to such drastic changes in their way of life that their culture suffered immeasurable damage...Our re-education will serve to bring more people home, to encourage our youth and lost ones to safely reconnect with their past communities (pp. 18-19).

A century of persecuting Indigenous Peoples' spiritual practices has left many communities traumatized and fearful of traditional beliefs, practices and medicines. Many Elders

consistently underscored the current reality that they are no longer authority voices in their communities. While Elders were the lead advisors and decision makers in Aboriginal communities, historically Indian Agents, Priests and their appointed Aboriginal "Chiefs" undermined their roles because they represented tradition, culture and spiritual leadership. The loss of Elders and diminishment of their roles and relationships with the broader community is one more fracture that leads communities into crisis.

Anderson (1999) argues that many urban Aboriginal people know they are Native but have no idea what it means which leads to poor self-esteem and feelings of alienation. She also concludes that not knowing what it means to be "Indian" is this generation's common experience tie as "Indians." She concludes finding ones cultural roots and heritage is deeply meaningful and has healing value. To have a sense of self, belonging and dignity is essential. The inter-generational impact of colonization resulted in a generation of children that were raised unaware of their heritage, roles and responsibilities (Pierre & Long Soldier, 1995). She argues that the historical authority many Aboriginal women once enjoyed was diminished through adoption of European ideals, displacing women from decision making. The recovery of traditional knowledge would improve the status of Aboriginal women and their families' overall well-being (Anderson, 1999).

Factor: Youth Suicide Prevalence in Communities in Crisis:

Nancy Miller's (1995) *Suicide Among Aboriginal People*, a report prepared for the Royal Commission on Aboriginal Peoples, provides the following:

The Commission report identified four groups of major risk factors generally associated with suicide; these were psycho-biological, situational, socio-economic, or caused by culture stress. Culture stress was deemed to be particularly significant for Aboriginal people. Situational factors were considered to be more relevant. The disruptions of family life experienced as a result of enforced attendance at boarding schools, adoption, and fly-out hospitalizations, often for long-term illnesses like tuberculosis, were seen as contributing to suicide. Socio-economic factors, such as high rates of poverty, low levels of education, limited employment opportunities, inadequate housing, and deficiencies in sanitation and water quality, affect a disproportionately high number of Aboriginal people. It is obvious that in conditions such as these, people are more likely to develop feelings of helplessness and hopelessness

that can lead to suicide and high risk behaviors such as alcoholism and drug abuse. Miller (1995) further describes 'culture stress' as a term used to explain the loss of confidence in the traditional ways of understanding life and living that have been learned within a culture (1996, p. Mr-13IE).

She recommends that the Royal Commission develop a strategy of action and a national campaign to address the incidence of suicide in Aboriginal communities, one that is developed and driven by the community. These services need to include provisions for building capacity for self-determination, self-sufficiency, healing, and reconciliation. She reports, that "this approach is to be based on seven elements: cultural and spiritual revitalization; strengthened family and community bonds, children and youth; holism; whole-community involvement; partnership; and community control" (p. 7).

The documentary '*Place of the Boss*' chronicles the experiences of the Innu of Labrador. Elders recall the Catholic Priest insisting to them that they do not drum, sing or conduct ceremonies claiming that it was a sin. Several Innu elders featured in the documentary felt the loss of their traditional activities was directly related to their peoples' addictions and high suicide rates. Davis Inlet and Sheshesit are examples of Aboriginal communities in crisis suffering devastatingly high suicide rates (Survival International, 2008). *A Way of Life that Does not Exist: Canada and the Extinguishment of the Innu*, explains that the Innu of Eastern Canada have extremely high suicide rates, ranking among the highest in the world (Survival International, 2008). This illustrated report describes their way of life, religion and society, and investigates their current situation. It explains how their forced transformation from a nomadic hunting people into a settled and dependent population has brought terrible social problems, and details the communities' own suggestions for regaining control of their land and their future (Survival International, 2008).

The Innu elders had identified the need for the Innu youth to know traditional ways. This knowledge was critical for suicide intervention and would help them heal, have self-esteem and assist in empowerment. This goes hand in hand with economic growth, educational success and Innu strategies for self-help and intervention. While there are no established indicators that conclusively define what constitutes a 'community in crisis,' there are communities that are fully aware their people are in need of significant support and assistance. The Elders voiced their concerns at the International Indigenous Elders Summit, 2004, suggesting they have answers but their views fall on deaf

ears (International Indigenous Elders Summit:2004, Six Nations).

Recommendations: Traditional Knowledge and Medicine as Protective Factors:

Indigenous knowledge enhances an inter-connected, inter-related holistic approach to addressing and analyzing social phenomena. This theoretical framework is drawn from a body of research that critiques western science from an indigenous viewpoint. It contributes to the emergent articulation of indigenous experiences with colonialism and oppression. The literature overview of indigenous scholarship demonstrates that the basis of indigenous knowledge is related to an indigenous understanding of identity, self-worth and self-determination.

The spiritual, emotional and physical well-being is dependant upon a number of variables including the political, social and economic positioning of Aboriginal peoples and communities. However, a community that is doing well, economically, does not mean they will automatically have lower suicide rates than a community that is considered impoverished. There are several factors determining the well-being of Aboriginal communities and this section will demonstrate how indigenous knowledge and traditional medicine can facilitate health and well-being by acting as preventative factors to many of the crises facing Aboriginal communities. Recommendations include identifying the leading factors that sustain communities in crisis and need to be addressed by intervention and prevention strategies as follows:

1. Colonialism as the root cause of communities in crisis.
2. Education as a tool for assimilation.
3. The loss of value and support for women.
4. Youth suicide prevalence in communities in crisis.

Restoring traditional healing practices and knowledge is a pathway to both empowerment and health for communities. The traditional knowledge once practiced in historical Aboriginal societies needs to be restored as an intervention to addictions and the epidemics facing Aboriginal peoples (Thatcher, 2004). There is also sufficient evidence that strengthening ethno cultural identity, community integration and political empowerment contributes to improving mental health in Aboriginal populations (Kirmayer, 2003). The Gathering Strength Volume underscores the need for Aboriginal people to restore healthy communities by restoring traditional preventative practices in health services as determined by

the community. Overall, RCAP (1996) provided over 500 recommendations for Aboriginal people in all spheres of their lives. Only a handful has been implemented thus far.

Lesley Malloch (1989) writes that through teachings from Elders, there is a strong belief that traditional principles of health based on the balance between the physical, emotional, mental, and spiritual elements, hand in hand with a traditional healthy lifestyle prevents sickness. Malloch writes that the Elders she spoke with were understanding of the need for western medicine but also expressed that it is vital that Aboriginal peoples return to core cultural values and traditional medicine. The Elders state: "This is the only way the people will become strong again" (Malloch, 1989, p. 10). Colomeda and Wenzel (2000), write that "[f]or Indigenous peoples good health includes practicing cultural ceremonies, speaking the language, applying the wisdom of the elders, learning the songs, beliefs, healing practices, and values that have been handed down in the community from generation to generation" (p. 245). The authors note that in indigenous health and healing, Elders have always played a crucial role in maintaining the health of the people. The Elders are the key players as they are considered to be wise and responsible for educating the people (Colomeda & Wenzel, 2000).

Indigenous literature on the topic of traditional approaches to enhancing well-being emphasizes ties to the land, language and culture. The land and physical environment shapes the cultural knowledge in achieving community well-being as practiced historically by Indigenous people. Definitions and measures of well-being include everything from diet, lifestyle, identity, knowledge of language and culture, positive verbal reinforcement, herbal and ritual knowledge, and traditional knowledge (heritage). In short, community wellness is connected to all areas of human activity; good medicine is a lifestyle that encourages a good state of being. It is a common Aboriginal belief that traditional culture and knowledge are important for promoting community health and well-being.

Furthermore, Svenson and Lafontaine (1999) report in their research that over 80 per cent of Aboriginal respondents answered 'yes' to the question, "Do you think a return to traditional ways is a good idea for promoting community wellness?" According to Nancy Zukewich's (2008) article, *First Nations Children Six Years Old Living off Reserve: Statistics Canada*, 46 per cent of young off-reserve children had engaged in "traditional First Nations, Métis, or Inuit activities such as singing, drum dancing, fiddling, gatherings or ceremonies" (p. 2). Also, 45 per cent of off-reserve children had someone teach them, had someone who helped them understand First Nations history and culture.

Most of these children were being taught by their parents (60 per cent) and grandparents (40 per cent). She also states those with status were more likely to have access to traditional knowledge (Zukewich, 2008, p. 1).

Recommendations: Traditional Medicine as a Protective Strategy:

Given the previously illustrated young demographic of Aboriginal peoples in Canada, it remains crucial to focus on the health and well-being of Aboriginal children and youth. Furthermore, because mental health is one of the most extreme issues facing Aboriginal communities, it requires significant attention including the promotion of intervention and prevention strategies that encompass traditional medicine and healing approaches. The demography also indicates that the young Aboriginal population is increasingly expanding which speaks to the current needs of young families. Therefore, the need for policies and practices supporting solutions for communities in crisis is critically urgent as was pointed out by RCAP (1996), approaches in preventing crisis and providing intervention strategies for Aboriginal communities. Integrating traditional practices was also identified by the RCAP (1996). It states that cultural and spiritual revitalization would strengthen family bonds since the activities of drumming, dancing and singing are collective and social by nature. Furthermore, Struthers et al., (2004) conclude that traditional medicine is still in widespread use and it is critical for health care professionals to have an understanding of the basic ideologies of holistic health which underscores an indigenous approach to health.

The host site of healing for Aboriginal peoples is within the ceremonial context. There, ideas and beliefs emerge and are reinforced through the physical, mental and spiritual experiences. The above literature reviewed and outlines ways to restore balance in all areas of life, including education, raising self-esteem, claiming their identity, asserting their dignity, learning their traditions, customs and spiritual teachings, and letting go of pain – all approaches have many facets. The healing is holistic, inclusive of improving mental, emotional, psychological, and spiritual states. The improvements of economic, political and social standings are interlocked with holistic aspirations of traditional healing practices.

The traditional knowledge Aboriginal societies possessed concerning the emotional and mental health, reproduction, nutrition, prevention and intervention, and physical care had been suppressed through the missionary and colonial era of the eighteenth century. The objective

of the literature review is to gain an understanding how traditional healing traditions from across Canada share their experiences, and how thoughts and aspiration are constructed in healing strategies. Aboriginal voices have been silenced in their struggle to heal Aboriginal communities which have often been recipients of ill informed government policies that privilege western approaches over indigenous approaches.

Aboriginal people would better assess the cause and treatment of Aboriginal mental health. Also, this work importantly serves to validate Aboriginal experiences which have often been denied by mainstream institutions and methods. Culturally sensitive assessment tools have the greatest relevance in 'treatment.' The authors argue that the role of colonialism in diminishing Aboriginal identity as a root cause to a myriad of mental health problems. The wounds of the past continue to fester and it is often in silence. The path to healing is voicing the abuse and receiving validation from culture. The high suicide rates indicate a crisis in mental health and maybe due to under servicing of First Nations communities' health systems. Aboriginal mental health strategies should be a priority in any current mental health initiatives within Canada (Warry, 2000). Aboriginal mental health issues are best understood in the context of colonialism.

The overarching themes suggest restoring cultural practices of Elders, transmitting knowledge and teachings to youth. The only barrier to this practice is youth not having access to them so they can inherit the knowledge. Elders have in the past been role models to community members guiding moral and spiritual teachings and providing emotional support. This has been disrupted by a variety of colonial influences. The traditional ways are viewed as an essential solution to community wellness (Soucy & Martin-Hill, 2005).

The works of several Indigenous scholars presented expose the direct link between historical events and contemporary circumstances for Aboriginal communities. Within an indigenous knowledge framework, identified as having excessively high incidence of addictions and or youth suicide.

The leading factors that sustain communities in crisis and need to be addressed by intervention and prevention strategies are as follows:

1. Colonialism as the root cause of communities in crisis.
2. Education as a tool for assimilation.
3. The loss of value and support for women.
4. Youth suicide prevalence in communities in crisis.

Health is viewed as a state of well-being not the absence of illness. An indigenous knowledge framework also places emphasis on collective forms of preventions and intervention at the family and community levels. The bio-medical model poses a one dimensional view of mental health and therefore justifying an Aboriginal specific strategy within an indigenous knowledge framework or paradigm. Key characteristics in indigenous knowledge systems are the inter-relatedness and interconnection between social, political, economic, and spiritual life intersecting with emotional and physical well-being. The variables of poverty, low-self worth and powerlessness are predicating factors to problems such as addictions. Overall, the summary of literature on mental health and youth brought out several themes and recommendations.

Indigenous Knowledge and Traditional Healing as key to Empowerment and Prevention

Synthesizing Warry's (2000) work, the following practices are fundamental components to ensuring a culturally strategic approach to addressing Aboriginal communities in crisis, utilizing traditional medicine and healing in an indigenous knowledge framework:

- Prevention over intervention.
- Cultural care including traditional practices.
- Collective care on a holistic scale.
- Long term care for children and youth, including prenatal care.
- Develop programs that include family support versus individual support.
- Culturally informed diagnosis and tools of assessment.
- Interagency collaborative strategies.
- Education of institutions and communities.
- Capacity building, recruitment and retention of Aboriginal health care professionals.

Warry (2000) suggest the community workers in the mental health sector are under-funded and have few community services at a historical time when they are critically needed. He underscores that the thematic areas listed are consistent in Aboriginal health literature but there does not seem to be policy changes to implement identified solutions to communities at risk or in crisis. Traditional medicine and healing are a substantial consideration for at risk or high risk communities experiencing high levels of addictions, suicide or violence (Warry, 2000). Again, traditional revitalization is underscored as a way to altering

behaviours that are destructive or pathological. Traditional ways require personal responsibility and accountability for one's well-being (ibid).

Mussell, Cardiff and White (2004) suggest the state of Aboriginal children and youth's mental health is a consequence of the following historical and contemporary issues:

- Profound impacts of residential school experience on family functioning.
- Multi-generational losses among First Nations people.
- Emphasis on collectivist rather than individualistic perspectives.
- Relevance of community-based healing initiatives. (p. 4)

Duran and Duran (1995) suggest that development of assessment tools that are culture-based are needed for improving the mental health status of Native Americans. The authors explain that the lessons learned from history need to be acknowledged and it is critical to develop culturally sensitive assessment tools and intervention strategies (Duran & Duran, 1995, p. 19).

A recommendation identified in the literature includes finding ways to restore balance in all areas of life for Aboriginal people, by incorporating traditional knowledge, bilingual education as a means of increasing self-esteem, reclaiming identity and asserting dignity, learning traditions, customs and spiritual teachings, and letting go of the pain. All the approaches have many facets and include multi-dimensional culture-based approaches. The emphasis of intervention and prevention strategies through the application of traditional practices requires communities, Elders and healers to develop these strategies in collaboration with community health service providers. Most important is to ensure the leadership, education and health institutions work together to move their communities out of crisis (Duran & Duran, 1995; Mussell, Cardiff & White, 2004; RCAP, 1996; Warry, 2000).

Stewart's (2007) work provides a description of the tools or methods that could be developed as indigenous models and practices of helping and healing. These tools are described as:

- Storytelling.
- Advice from Elders.
- Facilitating interconnectedness with family and community.

- Healing circles led by professionals and Elders.
- Ceremonies.

These tools are examples of approaches to developing culturally significant intervention and prevention strategies that can be incorporated into health services for Aboriginal communities. Stewart (2007) further explains that these indigenous methods and practices for helping and healing need to include the involvement of local communities, Elders and traditional helpers.

The overarching themes in the literature are congruent with self-determination and enhancement of restoring traditional knowledge, medicine and healing which are rapidly becoming vulnerable due to lack of transmission and training. Currently few communities have the resources to recover and revitalize their language and culture. Policy should acknowledge traditional knowledge as a critical component to success of preventative and intervention strategies for Aboriginal communities. Indigenous knowledge is a key to resolving communities in crisis however, it must be noted that it is a rare resource due to the age demography, loss of identity, cultural knowledge, and healers; therefore incorporating traditional knowledge should take priority. Furthermore, efforts should be made to retain this knowledge as a community resource for helping and healing in the future. The most important recommendation is to develop resources for the continuance of traditional healing, language and knowledge with vigor.

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Resilience and Aboriginal Communities in Crisis: Theory and Interventions

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ABSTRACT

Resilience in Aboriginal communities is a long process of healing that allows to supersede the multiple trauma and the loss of culture experienced during the colonization and after. The presence of social capital is central to this process in building bridges between persons, families and social groups with the aim of developing a spirit of civic culture. The process usually relies in the first stage on the vision of a few leaders whose example brings forward a larger segment of their community. Characteristics specific to the notion of resilience in Aboriginal cultures are: spirituality, holism, resistance and forgiveness. The main obstacle to overcome in the process of resilience is the phenomenon of codependency which leads to superficial attachment, lack of trust, and refusal of authority. The concept of cultural identity is central to resilience in this context and there is a need to create a new cultural ethos in continuity with the traditions. Each community has to undergo its own course and cannot copy success stories, mainly be inspired through a process of lateral knowledge transfer. Finally, community resilience has to rely on the capacity of families to be resilient themselves which involves breaking the law of silence, naming problems and coping with them with the support of networks and institutions.

KEYWORDS

Resilience, Aboriginal, community health, family, social capital, trauma

INTRODUCTION

This report is an attempt to explore the pathways to resilience among Canadian Aboriginal communities facing a period of social crisis. The challenge for many of these communities is to overcome the historical burden of colonization, to repair their social fabric, and to assert pride in their culture. Some attempts to put an end to violence and social disorganization have achieved important marks but there is no single model to reach solutions; these experiments represent nevertheless a source of inspiration, hope and wisdom for the future.

The first part of this report reviews basic theoretical concepts omnipresent in this literature. The central concepts are resilience and family resilience, social capital, cultural

identity, and spirituality. Resilience will be the guiding concept. It refers to an ongoing, process extending over many years even in the best of cases. In order for resilience to take form, a community should include a minimal number of persons with sufficient psychological and social resources to initiate a movement towards change. They can then progressively build efficient organizations, both formal and informal, to apply solutions. This process requires the empowerment of strong and reliable leaders at all levels, in women and men of all ages, in order for the community to recapture a sense of dignity.

The second part of this report focuses on Aboriginal experiences, mostly Canadian, which have tried to enhance

the social capital and resilience of communities in crisis. Other interventions were based on culturally adapted programs, targeting more specific groups, with outcomes that have contributed to the well-being of the whole community.

1 Resilience

1.1 The long road towards resilience: a global framework

A large number of Canadian Aboriginal communities are experiencing a period of acute crisis due to historical policies whose explicit goals were to annihilate their culture. On the psychological level, many factors have contributed to the diminishing strength of the family and to increase the vulnerability of the children who were socialized in these families during the last two generations. The goal of this report will not be so much to document this process of disintegration which has been fully described elsewhere (Royal Commission on Aboriginal peoples, 1995; O'Neil & Mitchell, 1996), but rather to indicate paths to resilience for these communities. As mentioned by many authors and as experienced by communities which have gone through a process of healing, building resilience is a process extending over many years, requesting a strong commitment from key leaders followed by a significant portion of their community. The consequences of many centuries of colonization, repeated trauma, both historical and contemporary, and an explicit national project of ethnocide, cannot be eradicated by a short-term intervention or a well-thought culturally adapted program. These events left deep scars on individuals, such that a state of codependency associated with alcohol abuse and lack of trust exist. In the best of cases, healing will require many years, involve some failures with lessons to be learned from, and may include only a handful of visionary individuals in the first step, setting the mark for others to follow.

A large space will be devoted to Sossan Abadian's doctoral thesis (1999) at this point because her work is the most ambitious attempt to understand the multiple challenges, psychological, social and political to be met by Aboriginal communities in order to become resilient. It has heuristic value in the sense that it offers a model to guide both thinking and interventions. The merits of her argumentation is to reiterate the central point of Putnam's demonstration (1993), that social capital is based on a civic culture or civic-ness, harboring such values as civic engagement, the pursuit of the public good, political equality, solidarity, trust, and tolerance. Once these values are sufficiently established, legitimized and shared in a given social group, they will lead to a rich network of

local groups and associations devoted to the well-being of their community. Among Aboriginal communities, these initiatives can take the form of brotherhoods or sisterhoods, political lobbies, vigilante organizations, and suicide prevention groups. In Putnam's view, these so-called civic values evolved out of dense networks that are the multiplication and reinforcement links within a community. Members who form organizations have to submit to a basic discipline in order to attend meetings or to fulfill concrete tasks; the social regulation of these groups should temper extreme or unrealistic discourses and favor the expression of a variety of opinions; these groups will also provide rewards when the tasks are completed. This social climate of trust characterizing these organizations should invite individuals to experiment with new ideas to change society and the organizations to take a collective responsibility for the outcomes. This is the essence of the concept of social capital which "...refers to the features of social organization, such as networks, norms, and trust that facilitate coordination and cooperation for mutual benefits" (Putnam, 1993, pp. 35-36).

Another important component of social capital is the interconnection of dense networks with information and activity flowing between them. For this to happen a number of individuals need to belong to many networks and these networks have to complement rather than to oppose each other. Without this central bridging dimension, social capital will be at the service of a few individuals only.

Unfortunately, social capital is sparse in Aboriginal communities facing a chronic state of crisis. As documented in Putnam's work in Italy and as observed in Canada, history matters. Traumatic events such as the period of the Residential Schools, often concurrent with forced permanent settlement, the loss of hunting and traditional lands and, with them, the loss of traditional survival means, has broken the social cohesion. Central means of identity such as rituals and religion were destroyed and traditional leaders replaced by missionaries and bureaucrats. In other words "collective trauma razes to the ground existing associational ties....and at the same time, it inhibits individual capacity to re-create viable and productive social ties" (Abadian, 1999, pp. 81-82). As a result, traumatized and confused survivors resort to drugs and alcohol to assuage their personal and collective sufferance's, their physical and mental morbidity increases, and they are not able to compensate their narcissistic or self-image wounds by identifying to a culture to which they would be proud. As shown by Taylor (1997), if someone cannot feel proud of the cultural group to which he or she belongs (collective identity), he or she will hardly be able to maintain a positive

evaluation of him or herself (personal identity).

Abadian (1999) also argues that if the number of people with emotional vulnerability is too high in a community, they will view the world with distorted perceptual filters and a subculture of trauma and addiction will emerge. Consequently, the main challenges to overcome psychological trauma is to get rid of co-dependency, antiauthoritarian attitudes and identification with the oppressive authority.

The presence of a large number of poly-traumatized individuals is one of the main obstacles to resilience in Aboriginal communities according to Abadian (1999). Traumas transform the minds of their victims by producing symptoms such as intrusion of painful memories, hyper-arousal, or strong emotional reaction to innocuous events, constriction of the mind, and a detached state of consciousness which make social engagement difficult. Victims of trauma, retreat from taking any risk that could rekindle their pain. Their emotional state is unpredictable, often chaotic and almost always painful if not under the influence of substances. Because of that, they don't trust themselves, and even more so, other people and institutions.

One of the components of the traumatic experience is the condition of captivity, or the incapacity to escape the control of the perpetrator. The space for captivity can be a home, a Residential School or a prison. In the case of Aboriginal peoples, their place of captivity can be the reservation where violence and unlawfulness is rampant. Some have compared reservations to refugee settlements (Duran & Duran, 1995). This metaphor would not apply to all reservations, but there are certain common characteristics with some of them: forced displacement of heterogeneous groups into a small territory, absence of means of production, high dependence on a central authority, and a low rate of ownership of residences. An additional outcome of traumatization is the phenomenon of codependency, well-known in the field of alcohol and substance abuse. It can be described as a strong need to relate to other people, to form intense and superficial relationships, but paralyzed by a fear and incapacity to develop trust and genuine intimacies. Central to our purpose is the fact that these individuals become dysfunctional parents and foster abusive family environments. The key note is the rule of silence or denying the existence of problems, the fear of emotional expression, and an exclusive and perverse loyalty to the family, which prevents interaction with other families.

The reason why codependency is important for the topic of social capital is that it prevents the creation of a sense of community. When people stop to trust each other, it nurtures paradoxically anti-dependent attitudes or a fear

to rely on others and to be betrayed later on. These co-dependant individuals are known for their reluctance to any form of authority, and they are the ones who strongly oppose decisions reached by the majority on the basis of compromise, dramatically torpedoing hardly fought consensual decisions. Institutions and organizations, on the other hand, are built on social contracts based on mutual trust and a process of give-and-take. These ingredients are the prerequisites of social capital.

Another issue related to Residential Schools is the identification with the aggressor. This well-known defense mechanism of the psyche is a recurrent theme in dominant-submissive relationships and a survival tool for the oppressed. Victims, in order to avoid the punishment from their torturers, have to get into the mind of the aggressor in order to predict their behaviour. In other words, they have to become like the bad authorities to read their intentions in order to please them, and avoid being hurt or destroyed. The snag is that the victims can unwittingly adopt the same frame of mind as the aggressor and feel the same need to dominate more vulnerable human-beings around them. This happened when some Residential School students returned back home and brought with them the "boarding school management style" they had been subjected to. Such a testimony is provided by Former Chief Harley Frank (as cited in Abadian, 1999). In the end, collective trauma originating from the government and the Church crushed the individual energies, depleting the "collective immune systems" (Abadian, 1999, pg. 203) in such a way that Aboriginal peoples were dispossessed of their cultural tools to resist colonial aggression. According to Lear (2006), a political philosopher, the disappearance of the Aboriginal culture had dire consequence in depriving whole cultures of their ethos, of what made a man or a woman a human being. This is equivalent to the French anthropology term *ethnocide* (Jaulin, 1974), an expression first coined by Raphael Lemkin to whom we also owe the term *genocide*. Briefly said, Aboriginal peoples not only had to endure trauma, but they were at the same time deprived of the tools of resiliency (beliefs, rituals and institutions) which usually help traumatized societies to reconstruct their identity.

1.2 The concept of resilience: a theory or a dream?

The concept of resilience has been a rallying emblem among Aboriginal communities and other oppressed populations because it inspires hope in the face of harsh adversity. A short history of the concept brings us back in the late seventies when workers in the field of psychiatry, Anthony (1983) and Garmezy (1983) among others, asked

the question why some children raised in conditions of high adversity were coping better than others. The concept of resilience as a trait similar to a personality factor has been gradually replaced by the notion of trajectory of adaptation (Luthar & Cicetti, 2000). Many authors who have recently written on this topic would agree that resilience is a long process of interactions between an individual and his or her environment to face adversity, and lead to the emergence of moral strength and a sense of optimism. There is good evidence that individual factors play a role in the construction of resilience (genes, personality traits and intelligence). However, key adult figures or “tutors of resilience” can initiate a change for the better in the life of a child (Cyrulnik, 2000). Characteristics of the environment and the culture are also necessary to support the process of resilience (Tousignant, 2004). A culture can offer models of success for instance, and this is the basis of an ongoing work in the Mohawk culture in the project *Roots of Resilience: Transformations of Identity and Community in Indigenous Mental Health* (Kirmayer et al., 2009). Other narrative studies have shown that culture presents a system of meaning to make sense of catastrophes and provide a minimal sense of coherence to its members (Ehrensaft & Tousignant, 2006). This is done by telling stories and providing an explanation for catastrophes such as the civil war in Rwanda. Similarly, Colson (2003) proposed the idea that refugees create myths in order to survive their ordeal.

If the social sciences have not been able yet to validate the concept of resilience as scientific at the level of the person, the concept of community resilience can only be conceived as a metaphor describing groups that manage their crises through a process of healing. The use should be parsimonious and authors ought to detail the characteristics of what makes a community resilient. So we can only refer to community resilience with caution, as a heuristic concept and work in progress. But it has a lot of appeal among Aboriginal academics because it points to the forces of a community aside from its limitations. In a short caption, it is rhetoric of hope.

1.3 Defining resilience in the Aboriginal context

Within the Aboriginal perspective, Healy proposed a general definition of community resilience as the capacity of a distinct community or cultural system to absorb disturbances, reorganize while undergoing change, retain key elements of structure, and identity that preserve its distinctness (as cited in Ledogar & Fleming, 2008). One of the challenges of applying universal literature on

resilience to Aboriginal people is to keep in mind that resilience may be viewed differently in these cultures. There are certainly universal, cross-cultural elements, but resilience should at the same time correspond to what these cultures recognize as familiar. There is a culture specific ethos supporting this concept in the social sciences literature which should not be uncritically transplanted to Aboriginal peoples. For Burack and colleagues (2007), resilience has to be integrated into a holistic world view uniting the mental, the physical and the spiritual. It would be difficult for a linear epidemiological model based on risk and protection factors to capture this reality.

Andersson and Ledogar (2008) reviewed a long series of studies on youth resilience in Aboriginal peoples of Canada. They found that personal assets were associated with individual resilience as found in the general literature but the factor of pride in one’s heritage also came out as significant. There was no clear association with spirituality but with the way to assess the various forms of spirituality. With regard to social resources, parental care and support, and peer support came out as important.

Because most resilience literature is centering on positive psychology and concepts of high social desirability, there is an aspect sometimes forgotten which is ‘rebellion’. For instance, an explorative work with four resilient Aboriginal informants showed that three of them rebelled against the situation they were experiencing (Sebescen, 2000). Projecting aggression outward allowed them to separate themselves from an abusive environment and find solutions. With regard to outside institutions, resistance can be a way to refuse policies detrimental to the well-being of the community. In the Zuni Pueblo village of New Mexico, a tourist guide describes the importance of a local brotherhood centered on this sacred value (personal observation). In an analysis of the Residential School legacy, Dion Stout and Kipling (2003) described how former students recalled that they were maintaining their pride by resisting and rebelling against the system or were wearing an imaginary mask to hide feelings. According to James Clairmont, a Lakota Elder, “the translation of resilience is a sacred word meaning resistance, to resist to bad thoughts and bad behaviours. We accept what life has to offer us, good or bad, as gifts from the Creator. We try to overcome stressful and difficult periods with a good heart. The gift of adversity is the lesson we learn when we pass through it” (as cited in Graham, 2001, pg. 1). It is not merely survival, it is about attachment, love, learning, laughing, and having a grasp on life (McAdoo, 1999). These notions of celebration and joy, less familiar in the universe of task-oriented academic psychology, could also be regarded as particular to

resilience in Aboriginal cultures.

Another characteristic mentioned by three informants in Sebescen's (2000) master thesis was *forgiveness*. This concept evokes the word reconciliation at the heart of the Canadian Commission of Truth and Reconciliation. There is an actual debate within the Commission and in similar peace initiatives regarding the possibility of reconciliation. Galtung (1996), a Norwegian peace expert, concludes that mutual respect is easier to achieve than reconciliation, a goal that he considers too idealistic. However, given the multiple intra-familial and intra-communal instances of abuse in Aboriginal communities, it is difficult to foresee how trauma can be superseded without creating peace through a form of forgiveness. Forgiveness is probably too difficult to reach in many situations, and interventions may have to remain satisfied if respect of the other has been attained.

Other researchers propose a holistic view of resilience around the concept of the spirit to replace or supersede the more familiar concept of self-esteem (Dell et al., 2008; Dell et al., 2005). They maintain at the same time a more classical definition of resilience as a balance between individual strategies of coping with adversity and the availability of community support. The spirit, contrary to the self-concept or self-esteem, is at the limit within the inside and the outside world, an entity one can identify with but also a presence one interacts with. This re-definition of resilience in Aboriginal terminology avoids the pitfalls of an academic solipsist psychology where the personal mind is the central concept.

1.4 Resilience and cultural identity

The discourse on resilience within Aboriginal communities has envisioned enculturation or a return to the traditional culture of the past as a fundamental path to healing. This movement contributed to promoting the revival of ancient or borrowed rituals in order, for instance, to prevent youth suicide attempts and alcoholism. As formulated by Santiago-Irizarry in 1996 (as cited in Holton, under press), the loss of culture is a constitutive part of the demoralization of communities, and cultural revival should therefore become a necessary aspect of the treatment. Holton and colleagues (2009), present a critique of a narrow view of traditionalism, supporting their position with works trying to offer a more dynamic and modern conception of culture. In this view, a culture is a social instrument to cope with contemporary challenges and it cannot be reduced to its past. This is the danger of the mummification of the past culture, turning it into a rigid mythical reconstruction of the past when in fact a culture is a living entity, repeatedly (even in the past) borrowing from neighbours. Along the

same line, Sissons (2005) coined the expression "oppressive identity" which opens up new forms of exclusion of people who don't fit the definition, forcing a constricted and narrow definition of Aboriginal.

Another issue regarding identity is how to define Aboriginal culture for the half of the Aboriginal population now living in cities (StatsCan, 2001). Enculturation for these people means a complex reconstruction of their cultural identity and this will be the challenge of many young people migrating to an urban life.

Kirmayer and colleagues (2003) stress the importance of collective identity as a lever to promote mental health in Aboriginal communities. This identity encompasses a pride in history and traditional culture but also in all the contemporary achievements and new ways of being Aboriginal. Instead of relying on a position of retreat from the outside world and interpreting the universe in a dichotomized way, the will to maintain a strong Aboriginal identity is not in opposition to some form of integration to the global culture.

Cultural revival can be healthy as claimed by so many authors and communities. But, for the process of resilience to take place, cultural revival should be reparative and not toxic according to a conference on the theme of Healing Our Spirits given by Abadian (2006). She reiterates Colson's idea (2003) that Aboriginal people have always recognized the power of stories. These stories or narratives help members of a community, particularly children, to attribute meaning to their tragedies and to anticipate a more positive future. They include moral lessons to confront adversity.

When individuals or collectivities undergo repeated trauma, they tend to build narratives that are disempowering. People feel shameful, that they deserve what happens to them, that it will always be so (permanency), and that everything is spoiled (pervasiveness) (Abadian, 2006). This discourse is similar to conversations recorded by the late Nova Scotian psychiatrist Leighton when he interviewed informants living in disintegrated villages; the daily conversations reflected their low morale. According to Abadian, the sentiment of defeat can also lead to its contrary, which is a falsely empowering narrative. In this case, people regard themselves as superior to others and the world as hostile. Using psychiatric metaphors, we could translate both types of discourse respectively as depressive and paranoid. Whatever the choice, the consequences are the same: people are generally viewed as unreliable, unworthy of trust and cynicism prevents will for action and change.

In contrast to this gloomy picture, Abadian (2006) adds that, “a healthy society has a medicine cabinet full of balanced, optimistic, gratitude-inspiring, and abundance-oriented narratives that tell of getting through dark times, the goodness of life on earth and the goodness of people, and how people are deserving of love, abundance and joy” (p. 20). In the ancient times, Aboriginal people were experiencing trauma from time to time due to the climatic conditions for instance, but their cultural mechanisms helped them face these hardships and reestablish confidence. When those cultural remedies were lost, narratives became debilitating and could lead to the dehumanization and the demonization of others. In Aboriginal communities, Christianity was forced on the Aboriginal people with a theology centering on an apocalyptic message of the end of the world, a glorification of self-denial and of total sacrifice. More recently, some form of extreme traditionalism may have contributed to maintaining a strict view of the culture and to operate divisions within communities.

The habit of constructing the world through stories has been found at the core of Canadian Aboriginal youth’s discourse on identity. This conclusion is based on one of the most ambitious research programs in Canadian Aboriginal studies, aiming to link individual development to the dynamic life of communities. This ongoing work of Chris Lalonde and Michael Chandler was first published in 1987 from observations in British Columbia and is now being tested in the Prairies. Chandler and colleagues (2003) report how personal identity is being built differently in the minds of Aboriginal and non-Aboriginal youth. Their purpose is to understand how a youth comes to think that they remain the same person despite multiple changes over a lifetime. Their interviews showed that a sample of mainstream Canadian youth use an Essentialist strategy (80 per cent) to construct their identity. In other words, they described themselves with physical attributes, permanent and more abstract personality traits, to show that they remained the same person over the years. On the other hand, the Aboriginal youth (70 per cent) described themselves with a more Narrative view. This means that they described themselves in the form of stories, bridging together various moments of their life.

Another conclusion from this series of studies is that personal identity in Aboriginal youth is closely correlated with cultural continuity as opposed to cultural disintegration. The demonstration of this statement relies on empirical observations showing that youth suicide rates are directly associated to an index of ‘cultural continuity’ which is used as a marker of resilience in a community (Chandler & Lalonde, 2003). Note that the authors want to avoid the

expression ‘resilient community’ in order not to stigmatize communities not doing so well. The components of ‘cultural continuity’ are the following: efforts to regain title to traditional lands, to re-establish forms of self-government, and to reassert control over education; the provision of health care, fire and police services; erect facilities devoted to cultural events and practices; participation of women in government; and control over the provision of child and family services. In conclusion, this data on the distribution of suicide rates in Aboriginal communities in British Columbia brings into focus the close association between individual behaviour and the characteristics of the community.

On the other hand, these results could also indicate that social capital, cultural continuity and empowerment are most certainly acquisitions evolving a long internal process of social organization. These leaders and citizens who fought for the maintenance, the promotion and empowerment of their culture had entered a process of personal transformation, or were raised in a more protected environment. Lalonde (2006) points out to this effect that traits or solutions that worked for one community cannot be automatically applied in a process of ‘standard knowledge transfer’ for another community. The danger would be to process all this information in a central data bank and to promote universally a set of ‘best practices.’ As the reader can anticipate, this caveat also applies to the present report. It would be counter-productive to parachute solutions even coming from other Aboriginal communities. What is best is to promote a process of ‘lateral knowledge’ exchange (Chandler, 2006), to stimulate creative and locally adapted initiatives rather than blindly copying solutions.

Lalonde’s (2006) comments underline a conception of cultural identity that is not static. In terms of personal identity or continuity, Lalonde argues that the construction of a core definition of oneself over time helps to commit oneself to the future and to face adversity. In fact, this is the whole French notion of ‘*responsabilisation*.’ In the same way, a group with a strong sense of cultural continuity will feel responsible for youth and children because they represent the future of the society.

This notion of responsibility is central in Leroux’ (1995) discussion on the consequences of Residential Schools. Parents whose children were taken away for years were told that they did not have the competence to take the responsibility of raising them. These children in return did not have a model of caring and responsible parents, nor did they acquire these skills at school. The result is that many of them felt overwhelmed by the task of being responsible for children. At the same time, tradition was that grand-parents

were sharing the responsibility, especially when parents were away on hunting trips. Now the new parents don't know what the limits are regarding the respective responsibilities of parents and grand-parents.

1.5 Comparing resilience across cultures

One of the most comprehensive comparative studies on resilience across cultures has been initiated by Ungar (2008), and Ungar and colleagues (2006), a Canadian researcher based at Dalhousie University in Halifax. This project called International Resilience Project includes samples of youths from 14 communities in five continents; Sheshatshiu, an Innu community of Labrador, being the Canadian representative in this survey. The conclusions based on qualitative interviews and on the signs of healthy development according to the communities state that there are both universal and culturally-specific aspects of resilience. For instance, ethnic identity was found relevant in many settings but to various degrees. The Child and Youth Resilience Measure (CYRM) was constructed to assess resilience, and participants were selected according to their level of adaptation as perceived by members of the community. There were 58 universal questions and 14 site-specific questions formulated by a local advisory committee. In this study, resilience is very specifically defined; it is the process by which a child is able to navigate towards or negotiate for resources and the capacity of the family, community or culture to provide these resources. But the resources searched for and provided should at the same time be meaningful to both parties. A child for instance may seek education and a good job, but if education is not valued and jobs are scarce, the youth may not become resilient. Other cultural differences were related to the style of child-rearing. In settings with a low level of safety, strict parenting was associated with a better outcome than a flexible approach more adapted to an environment where children were less exposed to danger. The main implication from this report is the necessity when intervening in a community to privilege local knowledge about the nature of resilience and evaluating the outcomes accordingly.

In a seminal work in philosophy, Lear (2006) showed that the reconstruction of the ethos is at the heart of cultural renewal. His analysis of the Crow history during the course of the nineteenth century claims that, what provoked the sense of cultural disorientation in the process of brutal assimilation by the federal state was the disappearance of the ethos. In other words, all these values contributing to make a 'real man,' to attract the respect of women and to motivate mothers to reproduce these virtues in their children were lost. Plenty Coups, the Crow chief, made the conclusive

declaration that when "the buffalo went away the hearts of my people fell to the ground, and they could not lift them up again. After this nothing more happened" (as cited in Lear, 2006, p. 2). After that, there was a kind of existential pain with all the outward signs of depression, but with people able nevertheless to continue to live a normal daily life, unlike what is observed in patients with a clinical state. There was no real motive for the Crow to keep on living, or to engage in projects with meaning. But the Crow, unlike many of their neighbouring tribes, have survived with great effort, thanks to the vision of historical chiefs who acutely perceived the no-end road and showed the way to the future. The transformation was not easy; people had to work from prophetic dreams which did not map out the precise directions but from which evolved new ways of changing and continuing the culture. Others tribes, in the absence of visionary chiefs, were buried in history.

We can conclude this section on the central concept of community resilience by underlining the long-term scope of this process by which an Aboriginal community first recognizes the presence of serious crises and then elaborates and implants strategies to overcome them. The challenge of building resilience is demanding because multiple traumas have depleted personal resources and did not nurture a climate of trust, interdependency and legitimization of authority. But, specific characteristics of resilience were observed in the Aboriginal environment, among them the role of spirituality and tradition, as well as resistance to outside aggression in order to maintain identity. Resilience is also closely related to cultural identity and continuity, reflected both in the capacity of governance and the pride in the Aboriginal culture. Finally, the telling of stories to instill hope is certainly an important dimension of resilience in Aboriginal groups.

2 Social Capital

Mignone and O'Neil (2005) have proposed an operational definition of social capital adapted to an Aboriginal setting. They assert from the start that the key elements of social capital have to serve the common good at the same time that they support each of its members individually. These authors then proceeded to an in-depth enquiry integrating a variety of approaches: interviews, focus groups, informal conversations, and observations. The 89 individual interviews covered three Aboriginal communities of Manitoba, two Cree and one Ojibway. Their definition of social capital in the context of Aboriginal communities reads as follows:

Social capital characterizes a First Nation community based on the degree that its resources are socially invested, that it presents a culture of trust, norms of reciprocity, collective action, and participation, and that it possesses inclusive, flexible, and diverse networks. Social capital of a community is assessed through a combination of its bonding (within group relations), bridging (inter-communities ties), and linkage (relations with formal institutions) dimensions (p. 16).

The bonding dimension is probably the most central for personal health because it concerns the quality of the relationships within a community. According to Putnam (2000), joining an organization cuts an individual's chance in half of dying within the next year. Bridging and linkage dimensions are more important for community resilience; otherwise, groups will consider only their own selfish interests. The resources in this model are represented by the physical (houses and roads), symbolic (cultural camp and traditional healing), financial (capital and grants), and human (formal and informal education capital) dimensions. These resources can be abundant in a setting but fail to be transformed into social capital if there is no mechanism for circulation. Culture, conceived in a very broad sense, is therefore the means by which these resources will finally serve the common good. As argued by Abadian (1999), trust is likely the foundation of a culture of social capital because individuals not trusting each other would not easily reach the necessary consensus to engage in a collective action needing a broad base of participation.

The main tools to circulate the resources are networks. The nature of these networks is probably more specific to a given culture, and to Aboriginal people. For instance, in Protestant America, we find all these social and charity associations related to churches. In French Quebec, new models of community organizations are in the form of advocacy groups which have sprouted after the retreat of the Catholic Church. In Aboriginal settings, family networks probably play an important role, but new types of brotherhoods are appearing and we will probably see new prototypes in the near future. Whatever the nature of these formal and informal networks, the important point according to Mignone and O'Neal (2005) is that they possess three basic qualities: diversity, inclusiveness and flexibility. Diversity means that these networks have different goals and types of members but their actions are to some extent coordinated; inclusiveness means that these networks are not exclusive, that some members belong to different groups, and that entrance into these networks is

facilitated as opposed to restricted. Flexibility refers to the capacity to adapt rapidly to changing situations.

Mignone and O'Neal (2005) provide in their monography various perspectives to analyses on how social capital is expressed in an Aboriginal community and they complement them with detailed illustrations. There are at least 36 possible combinations in their model and one will serve to illustrate their approach. For instance the combination bonding social capital: networks: flexible, examines if the family networks are collaborative or at war with each other. A study wanting to predict health and well-being with these attributes of social capital would have to select items that seem more promising and devise measures based on qualitative measures in the first stage. For instance, trust could be assessed in the discourse of daily encounters and formal activities, whereas participation could more easily be assessed by the number of people coming to public meetings.

In brief, social capital can be conceived as the presence of various resources within a community, but these resources need to circulate between different groups, men, women, grand-parents, and youth, in order to construct social capital. That is to say that the bridging dimension is even more important than the bonding dimension, and that trust is what fuels productive exchanges.

3 Family resilience

In Aboriginal communities, the concept of family is almost coextensive to that of the community. The community is formed of nuclear and extended families and the family is at the core of a person's identity, even though a high number of families have been broken by divorce and a significant number of children are born to single mothers. For this purpose, we think that resilience of the family is a building block to resilience in the community and many initiatives of community healing processes have started by dealing with violence within the family.

The concept of family resilience is relatively new (Hawley & Dehann, 1996; Walsh, 1998) and certainly less well delineated than the concept of personal resilience. McCubbin and McCubbin (1988) propose various qualities contributing to a family's ability to cope with the change and crises taking place in their family. Later contributions have included the notions of growth, and the acquired capacity to face adversity within or outside the family (Walsh, 1996; McMillen, 1999). Hawley and DeHann (1996) argue that family resilience is not a factor easily defined and measured. According to the model of

McCubbin and colleagues (1998), the family's strengths include the personal attributes of its members, such as personality traits, coping capacities, intelligence, ethnic identity, and community resources. Families are also helped by institutions like the school, the church, the services, and public policies that will support them in facing adversity. This model borrows many elements from the classical theory of coping. There is first the necessity to define the situation as stressful, and recognize that a problem is present as opposed to the law of silence. Then the family unit has to assess its capacities, to establish a plan, take coherent action and be confident that a solution is possible.

Walsh (1998, 2006) stresses that a resilient family shares beliefs and a vision of the future to face what is within its reach and is resigned to what cannot be changed. More concretely, his approach calls for clear communication, the expression of a variety of emotions, empathy or openness to others' emotions, and joint decision making to solve conflicts. Families with positive models and the absence of alcohol and drug abuse offer feelings of security for the children (Hazel & Mohatt, 2001).

Literature on the social pathology of the Aboriginal family, have contributed to the construct of an image of the Aboriginal family as inferior to the family of the dominant culture (Laboucane-Benson, 2005). Despite this misconception, Aboriginal families can have powerful reserves of resilience (Keltner, 1993). The mere fact that these families have been able to survive oppression and assimilation is a testimony of their resilience (Laboucane & Benson, 2005; Lafrance et al., 2007).

Cross (1988) offered a cultural definition of family resilience in the context of the Aboriginal world. His model includes four fundamental dimensions for a healthy family: the contextual, the bodily aspect, the mental, and the spiritual.

In summary, with regard to the context of the Aboriginal family, we can conclude that cultural identity and spirituality are important determinants of health and resilience. But this cannot be achieved easily without strong community factors like the presence of leadership, relational capital (Mohatt et al., 2004) and peer support or natural helpers (Waller & Patterson, 2002).

Resilience intervention projects

3.1 Review of literature methodology

A trained librarian completed a survey with the following academic data banks: Pubmed, PsychInfo, Dissertation Abstracts, and Current Contents, looking for publications on Aboriginal people either in French or English covering

the area of North America and Australia-New Zealand. To search for material on resilience, we used synonymous words like "resiliency," "resilient" and "hardiness," as well as expressions like "resilience psychological," "adaptability," "emotional adjustment," and "psychological endurance." Other key words were "social capital" and "well-being." The research yielded a large number of items, some of them central to the theory of resilience among Aboriginal people, but very few articles described intervention strategies or programs in these communities and even less with references to resilience or social capital. Few older items were found in the bibliography of the most recent articles. In order to reach the so-called grey-literature of non published reports, we used the search tool Amicus from the National Library in Ottawa which covers the network of Canadian libraries. An additional strategy was to search in the sites for the main Canadian Aboriginal Journals such as *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health* and the *Journal of Aboriginal Health*. Finally, we used the Google internet site which provided a few items that our previous searches had not produced.

Many listed projects have recently been completed or are not yet terminated; the personnel of mental health projects in Aboriginal communities were contacted. The National Network for Aboriginal Mental Health Research (NAMHR) had just completed a list of these projects with their addresses (<http://www.namhr.ca/resources/programs/>). An email letter to these groups yielded very little not to say that many messages bounced back. Finally, we used the list of research members of this national network, five of which led to relevant material. We are aware that such a complex overview could not be accomplished within the time at our disposal without running the danger of missing important items.

3.2 Description of projects

3.2.1 Community projects involving the whole community

In order to create the conditions for resilience in a community, there is a need to involve a sufficient number of individuals. Four of the listed projects correspond to this criterion: Alkali Lake, Hollow Water, Nutashkuan, and Kitchisakik. The first community, where a radical transformation took place was Alkali Lake, a Shuswap group from British Columbia (Furniss, 1987; Abadian, 1999). The first signs of change appeared in 1972 but the peak of the movement was not reached until 1976. This was a landmark project because fundamental problems paralyzing the social life were confronted. There were serious attempts to stop

bootlegging and to cope with sexual abuse from which 80 per cent of the women had suffered. Other initiatives were concerned with self-governance; the band council took control of the Social Assistance funds and distributed vouchers instead of checks to recipients with a problem of alcoholism. A network of peer support was organized for members going into treatment so as to take care of their household and rehabilitation was helped by an employment program. As a result, the majority of the population became sober only five years after the momentum, created in 1976. Consultants and professionals from the outside, especially from the Four Worlds Development Project in Alberta, and the RCMP, were called to assist. This success story became, at the time, a beacon for other Aboriginal communities in North America who wanted to enter a process of transformation.

Another similar experiment widely known in Canada took place a few years later in 1984 (Four Worlds International Institute, 1984). The setting was in the region of Hollow Water, north of Winnipeg, and it included First Nations as well as Métis populations. An initial core of three persons grew to 30, and they were first trained by practitioners in Alkali Lake. A program named Self-Awareness For Everyone (S.A.F.E), was implemented to engage the participants in a process of healing, and to develop trust among them in order to launch a strategy of social development. The problem of sexual abuse was faced by offering perpetrators the choice to go to jail or to enlist in a five-year journey of healing.

The third large scale experience has not been so minutely documented, but it is comparable to the observations of the first two locations (Leroux, 1995). In the 1980s, women from the Anishnabe-Algonquin village of Kitcisakik (Québec) decided to ask the band council to do something against sexual abuse and domestic violence. This village is among the few without native status on reservation and consequently without schools, water system or electricity despite the fact that Hydro Québec runs a plant in the middle of the village. A complex judiciary process was launched after complaints were expressed by victimized women. No less than 35 men, or about a quarter of the adult male population, were sentenced and imprisoned. A rehabilitation program monitored by Portage, a well-known detoxification center, involved the network of the family and group therapy to facilitate the integration back into community life. This intervention by legal and health services contributed to improve the security; at the same time that the community became dry, without alcohol.

A fourth community healing intervention was reported for years 1999 to 2003, in the Innu-Montagnais

village of Nutashkuan on the North Shore of the St-Laurence River near Labrador (St-Arnaud & Bélanger, 2005). The intervention was centred on therapy retreats of up to ten days in a nature camp located in the ancestral hunting territories. The program was strongly influenced by traditional Aboriginal spirituality; both healers and professional psychologists collaborated in this venture. About half of the adult population (200 adults), in the form of small groups over a three-year period, participated in a camp which was accompanied by preparation and follow-up activities. An important goal was to deal with the psychological and moral pain of the participants and to bring to the surface the bad memories of the Residential Schools in order to put an end to the intergenerational transmission of traumas. The strategy led to a steep drop in the rate of consultations for domestic violence during the year after.

A lesson to learn from these wide scale community transformations is that the road to resilience follows a strenuous path, orchestrated by strong-willed individuals with a collective vision for the future. There are no easy, short-term, solutions. It has been repeated in almost each article, the legacy of the trauma of Residential Schools and the impacts of colonization still felt today cannot be eradicated within a few months or a few years. Even in these significant and highly publicized experiments, there was still a long way to go. Problems have diminished but have not disappeared. One of the problems noted in Alkali Lake and in Kitcisakik is that the next generation of young people do not automatically follow into the steps of the parents and that some further action should be taken to keep the momentum.

In most accounts, there were core individuals who first went through some form of personal healing and were ready to face all kinds of adversity and opposition in order to lead their band towards hope. Because they had been aware of their own vulnerability, they knew it was difficult to overcome a problem with alcohol and the denial of reality; they were ready to be patient with other members before they completed the various stages towards healing, a process often accompanied by relapses into alcohol and demoralization.

The healing process strongly relies on spirituality, traditionalism and the supervision of experienced healers. At the same time it includes the collaboration of Aboriginal and non-experienced healers. At the same time it includes the collaboration of Aboriginal and non-Aboriginal workers and professionals who bring their art and sciences to the service of the community. They usually have a lot to learn from each other in this mutual enterprise.

Psychological and social dimensions are both involved in the process of change. The Alkali Lake experience started

with personal self-awareness training and was later followed by a process of holistic community health development including economic development initiatives, continuing education and organizational development. The other projects also included social development and some form of individual therapy.

Another important observation is that a community can hardly build some process of resilience without facing the sensitive problem of sexual abuse and family violence. Depending on the community, it can request the support of the official system of justice or some form of community based justice programs (Aboriginal Justice Strategy). It would be important to detail how each community faced and worked through this problem in order to serve as examples for other communities. It is central to this strategy that serious crimes do not go unpunished. Women, for instance, should be assured that a sufficient number of persons are ready to support them if they feel threatened. A climate of safety and common sense should then prevail in the community.

In all these communities, there was also a strong cultural and spiritual element, providing pride in the Aboriginal identity. The spiritual element was not an attempt to go back to a lost paradise and to recreate a culture as it was believed to be before, but an inspiration coming from elements borrowed from the local tradition and other North American groups. In most of these experiments, the high moments of the spiritual and therapeutic experience took place outside the reservation. Participants felt the need to move to the more sacred space in the forest. We were also told repeatedly by Algonquin-Anishnabe and Attikamekw informants that people expressed themselves more easily in the context of nature, away from the tensions and obligations of daily life. The reservation is also perceived by some as a place of forced migration and alienation.

The national grants program of the Aboriginal Healing Foundation (2003) which included 384 grants by 2003 has been classified in this 'community category.' It is difficult to assess the impact of this huge sum of money of 285 millions dollars because projects were not individually assessed. This effort has certainly contributed to the social development and competence among Aboriginal people because 90 per cent of the staff was Aboriginal. The evaluation report of the Aboriginal Healing Foundation proposes some conclusions related to community resilience. For instance, it is said that perpetrators of crimes have to be dealt with in some form of justice in order to build a secure and predictable community. It is also repeated that healing takes time and the process can start only if a sufficient number of people are ready to join and to make personal sacrifices. When the community

denies the presence of a crisis despite strong evidence, education should be the path instead of proceeding prematurely to the stage of healing.

We have chosen to insert in this section a research-action project named Making a Difference (Smith et al., 2007), because the conclusions can apply to more general projects than the ones on parenting roles. The researchers asked community members what were, in their view, the basic ingredients required for this project to have an impact. The conclusions were similar to those presented above. The consensus was that change needed time, many years, because the long-term consequences of historical factors on individuals could not be turned around in a matter of a couple of years. This was also true at the individual level. For instance, a mother would not likely adopt a completely new ways of life after her first pregnancy. The improvement of the behaviours was gradual and was observed during her subsequent pregnancies. The second conclusion was the necessity to opt for a strengths-based approach with a positive psychology mind-set, which means to take advantage of the assets of a community rather than putting efforts in repairing what is wrong. There is the necessity to break the silence, to speak out, and in so doing, to assert a pride in oneself. The third point was the fact that you cannot change behaviours superficially with recipes and learning some basic skills. The real solution is the healing path, which requires confronting the real problems, from all forms of addiction to family violence.

3.2.2 Target-group projects

The great majority of the reviewed projects were oriented toward a specific clientele based on age, gender or a life situation, such as pregnancy. The projects selected didn't necessarily have as an explicit goal to increase empowerment or social capital. However, most were intensive and requested participation from the entire community. Some had a specific goal, such as preventing suicide or inhalant abuse, while others had more general aims like teaching skills to school children. It should be added that from an ecological perspective, if a category of persons, mothers for instance, initiates a change in their way of thinking or behaving, this change will have an impact on their family and on their community.

Three projects intended to teach skills to school children. The Zuni Life Skills Development program was only one of two U.S. programs officially recognized as an evidence-based practice by the Substance Abuse and Mental Health Services Administration of United States (LaFromboise & Lewis, 2008). It is an intensive full-year program with three activities a week. The other two

programs from Quebec, Zippy in Kitigan Zibi (Denoncourt & Laliberté, 2007) and Nokitan II in Wemotaci (Rousselot, 2009), offer a one hour-long activity a week over the school-year. They have the same explicit long range goal as the Zuni project: to prevent suicide and other self-destructive behaviours. In fact, these projects are in the category of health promotion rather than prevention in the sense that they target all the students rather than high-risk children, although the difference between both groups is not always big in a community in crisis.

The three above projects have collaborated with local educational leaders and other adults to adapt their program and include cultural material. For instance, Nokitan II worked with a group of woman over many months to write myths and legends from the Atikamek culture. With regard to evaluation, the Zuni program has been found to decrease feelings of hopelessness in Aboriginal communities, while Zippy is in the process of evaluation in Kitigan Zibi but has been validated on large samples of European and Quebec children.

Nokitan II and Zippy both have a strong empowerment component. They adopted tested approaches like group discussions, art creation and philosophy for children. The adults who lead these activities, usually teachers or educational workers, have to go through a personal process during their training, to face their own silenced emotions, and to deal with their family and other emotional situations that are evoked in the material. The program also creates a group spirit among the educators who feel that their task is also about increasing the well-being of their students. The inclusion of cultural material is sometimes in their heritage language, which brings collective pride. What is left to know is if such a program can influence the families' climate by facilitating emotional communication. Will these students maintain the positive outcomes when they grow older and enter adult life? Whatever the response, these programs are not only about teaching skills but about changing the social culture of a community by facilitating verbal exchanges.

The Aboriginal Youth Suicide Prevention Strategy of Alberta (The Aboriginal Youth Suicide Prevention Working Committee, 2003) applies a different approach to older children and youth. It requests communities to organize creative activities of all kinds and to increase the cultural knowledge by promoting nature camps and programs integrating younger people with Elders. Many adults are supporting these activities and these programs should nurture intergenerational links as well as a sense of community. Though these projects are not oriented toward healing, they reach their goal of instilling optimism and increasing attachment toward the culture and the

community. This provincial-wide strategy covering 17 groups is a rare example of systematic evaluation, even if the pre- and post-design was absent. There was evidence from surveys that youth improved their well-being and feelings of empowerment despite the fact that core signs of social anomie like alcohol and drugs consumption and violence had not changed for the better. A long-term evaluation would be necessary to assess the community outcomes.

Another change applied through the educational systems was to offer the choice of the local Aboriginal language in the first years of the primary school (Taylor & Wright, 2003). These educational initiatives had no explicit goals of empowerment and social capital at the start. Nevertheless they strongly support the argument that introducing Inuktitut at the beginning of primary school significantly helps to acquire better intellectual capacities, taking into consideration that the native language is already mastered by the children before they enter school. They also increased personal and collective self-esteem compared to students only taught in English or French. An unintended result was that Inuktitut children had higher scores than the U.S. average for children of the same age when tested with a western standardized test of intelligence. If traditional language acquisition in primary school helps boost academic performance at the same time as intellectual capacities, then it would be interesting to test if it can prevent dropping out of school later on.

Another series of projects named The First Nations Partnership Programs (FNPP) promoted similar goals (Ball & Spence, 2003). The idea was to integrate traditional knowledge early in the curriculum, and by so doing, keep more students enrolled and attract them to stay in the community. This should be a plus for the social capital component because these students will be able to use their skills to promote the community. This project initiated in Northern Saskatchewan and applied to other sites in Western Canada could boast that four times more of its students enrolled in college programs completed their degree compared to those not enrolled and 11 per cent registered for a bachelor degree.

The last project oriented towards young people was a therapy intervention experiment outside the community with youth 12 to 26 years-old having a history of inhalant abuse, called the National Native Youth Solvent Addiction (Dell et al., 2005). The nature of this project was similar to the first four community-wide projects with a strong personal change dimension. Spiritual and therapeutic interventions were based on traditional and western knowledge. One important characteristic of this project

was the integration of the family in the process and the support of local volunteers. Youth were also taught to use local services when they returned to their community. The communities had to be considered ready to receive and to participate in order for the intervention to take place. The program also helped promote the return to school.

Another series of projects were concerned with mothers. The most structured project was the application of the PRECEDE-PROCEED model for the prevention of diabetes (as cited in Salsberg, 2007). It is a multi-year community-based participatory research project developed by Ann C. Macaulay in Montreal. In the first stage, two models were tested in two communities, Kahnawake near Montreal and Sandy Lake in northwest Ontario, to modify habits of diet and physical exercise. Moose Factory in northern Ontario discussed the results of the first two interventions and went on to build its own strategy with the mobilization of its leaders and its community workers. The latter collected the data and analyzed the results of the research-action project to ensure its ownership. By doing so, the project builds a reservoir of trust, deemed necessary for the success of the implementation of the program based on this data. The project promotes the idea of providing tools to a community and to help the implementation of their own program. The community workers are offered basic training and they take responsibility for gathering the data. This intervention is a good example of a model where research is not seen as a tool of alienation but as a means of health promotion.

Two projects belonging to the community category were implemented outside of Canada. The first one reports on a men's support group in Yarrabah, Australia (Tsey et al., 2002). Aboriginals in Australia have more than 300 such groups. The group under study promoted the capacity to become more integrated into city life. This type of initiative could be more applicable in an urban environment where the problem of isolation among men is more acute than in rural communities.

The second project was an evaluation of the 1978 Indian Child Welfare Act enacted to promote cultural and familial preservation for Indian children in the United States (Limb et al., 2004). Some similar initiatives have taken place in Canada but have not been evaluated to our knowledge. Child placement is certainly one of the biggest actual challenges in Aboriginal communities because it could perpetuate the legacy of Residential Schools and deter the image of communities. Having a more culturally adapted policy of child placement can prevent some of the negative outcomes. It was found in Southwest United States that the

1978 Indian Child Welfare Act can lead to placements more in agreement with the will of the communities. The court also took measures to prevent the breaking of the family prior to the removal of the child and applied active efforts to reunify the family if a break-up had occurred.

3.2.3 Parent-children projects

At the national public health level, a majority of projects are oriented toward family and parent-child interactions. We had anticipated more publications on that theme in Aboriginal communities of Canada but almost all of the items found came from Australia and United States. There are certainly many initiatives in this category in Canadian Aboriginal communities but they have not been assessed to this day. Because the problems encountered in other Aboriginal communities presented similarities with the challenges met by Aboriginal families in Canada, we believe that lessons learned from these projects can be useful to plan family programs in Canada.

The Healthy Families Program use home visits to improve child-care, consisting of pre- and post-birth programs to promote child care skills either with high-risk groups such as adolescent mothers or mothers in general. Two evaluations of the Healthy Families Program were quite positive, resulting in the prevention of serious injuries and even death (Caldera et al., 2007). The results indicate less stress and conflicts in participants than non-participating families. In the second evaluation, there was a significant effect on developmental and behavioural outcomes, but they were not specifically identified (Nations, 2005). As in many programs trying to improve family skills, families who did better before the implementation of the program received more benefits from the intervention. A possible explanation is that they understood the goals better than families with multiple problems because they had more personal resources, did more practice and discussed the tasks with other parents. The other intervention with adolescent mothers also improved maternal involvement with the children but not the skills to take care of children (Barlow et al., 2006). Given that the well-being of young children is an essential asset for the future of communities and given the costs of child abuse for the public health and social services, early intervention in the form of perinatal programs is usually a priority in a prevention strategy. One popular form of intervention was home visits by para-professionals to pregnant mothers for a period of many months. In the case of a high-risk pregnancy, mothers with a problem of substance abuse for instance, a more professional type of coaching may be required.

A series of other programs have attempted to increase parental competence at a later stage. The Positive Parenting Program in Australia has put many efforts into culturally adapting its strategy to an Aboriginal environment (Turner et al., 2007). The sessions with parents were in group settings and led by nurses and other health care workers. The evaluation was done with a randomized clinical trial and with interviews. The effects included positive influence on child behaviour which was maintained six months after the end of the program. It is worthwhile to observe that the success of this program was related to a decision to adapt it during its application so that the social and political context could be discussed, in order to build trust with the participants. It was also necessary to reduce the speed of the verbal content of the material so that participants could better understand its messages. Another Australian project was a cultural adaptation of Triple P (Positive Parenting Program), and was named the Whyalla and Upper Eyre Peninsula Parenting Project (Burgess et al., 2004). The purpose of this program was to teach positive strategies for interacting with and disciplining children. The evaluation was positive but no systematic testing was done. The last project of this nature, the Indian Family Wellness, for families with preschool-aged children, had not yet reached the evaluation stage (Fisher & Ball, 2002). Its specificity included cultural activities, participation of the extended family and the use of storytelling. It would be interesting to know if this more community oriented approach has more impact on motivation than public health type projects such as the Triple-P. Another issue is whether families need to learn child-care skills as much as to define and apply priorities for their children.

The program Sing and Grow is an original Australian project which uses musical therapy to put learning into practice (Fisher & Ball, 2002). This tool is seen as more appropriate to develop close relationships of love within the family and to get closer to the traditional culture. Unfortunately, the evaluation was not completed. Another early intervention project was based on parent-child or filial therapy and aimed to increase parents' empathy towards their children and included a support group for parents (Glover & Landreth, 2000). The evaluation has shown an increase in play with children and in empathy, but there was no significant effect on the children's self concept.

Two other programs were concerned with parental competence and school preparation for young children. The national American program called The Family and Child Education (FACE) has been tested on 25 different tribes in the U.S. (Emberton, 2004). It introduces children to literacy and trains parents to play a central role in their children's

education. The program is based on Aboriginal philosophy and the personnel are selected from within the community. The FACE program also includes an early intervention module to integrate families and schools (Field et al., 1996). There is in addition a literacy module for parents.

In western settings, gifted children have problems adapting to school. It is even more so in the Aboriginal environment where the school drop-out rates for these children can negatively affect the social capital of a community as these children grow into adults. Project Eagle was conceived to face this challenge in the Aboriginal communities of Australia. According to the authors (Robbins et al., 2002), the program helped students increase their self-esteem and feel more connected to their community.

One project is intended for parents with adolescents, the Resourceful Adolescent Program for Parents (RAP-P) (Harnett et al., 1998). The aim is to promote self-confidence and self-esteem in parents with the hope that it will translate to their adolescent children. An important aspect is communication within the family and the promotion of harmony.

After reviewing these parent-child oriented projects, one spontaneous question which arises is whether these interventions are sufficient to increase social capital and resilience in a community. Because the articles have not sufficiently dealt with this question, which was not central to their concern, it is difficult to provide a definitive answer. It is likely that most projects of this nature, if intensive and including a large number of participants, could have in the long range an effect on increasing the resources of the children who are going to be the future citizens of their community. They can also act on parents and change their cultural values, integrate more spirituality into their life, reinforce Aboriginal identity, offer an opportunity to experience a group situation where people share their personal concerns, and start to develop a certain degree of trust in each other.

Many of these projects were adapted from middle-class oriented programs. They require a minimal level of motivation, capacity for conversation and interaction, and sharing with others. Consequently, these programs will probably bring more profit to literate parents with less stressful conditions in life. For parents carrying the burden of multiple trauma and alcoholism, living in a family culture of silence and with a serious problem of attachment towards their children, there would be the necessity of a long process of preparation and healing before involving them in such programs.

4 Conclusion

Resilience and social capital are central issues in Aboriginal communities, and some people have evoked an interest in constructing an index for their assessment. At the end of this review, we can only say that this task would be complex and, to many authors, a dangerous enterprise threatening to stigmatize communities who would achieve a low score on such a scale. What is more appropriate is a model integrating the main themes to analyze. But in the same way, a psychoanalyst cannot make a good assessment of certain psychological dimensions of his or her client before many weeks; it would certainly take a few months before drawing reliable conclusions on how a community stands with regard to the main criteria of social capital or resilience. Only if a community stands at some positive or negative extreme would it be possible to quickly reach a conclusion but the large majority of communities stand between these two poles. The dynamic can look excellent one year and recedes to the baseline the next year, following a political crisis or a series of suicides.

With regard to social capital, Mignone and O'Neil have accomplished state of the art research and looked at every possible aspect of social organization. They concluded that the bounding dimension is the building block of social capital. The networks generated by the associations between individuals are the main tools to build social capital. Those dimensions can be operationalized to some extent, but even with a good valid grid, it would take a long time to draw the social capital map of a community. When active formal organizations are present, the task is relatively easy. When these networks are found in extended families and the level of communication between these networks is low, the assessment is much more difficult.

With regard to resilience, there is no easy way to capture the state of a community. If the best way to assess resilience is to look at its capacity to transcend a crisis, then we could have a very negative view if the community is actually going through a crisis. The question of resilience cannot be asked in the usual academic way for Aboriginal communities. History has been different. The basic question is that of healing, and healing here is not a vague metaphor but refers to the pain of multiple traumas experienced by a large number of adults and these traumas are being reproduced from one generation to the next. The process cannot be initiated without some form of *visionary leadership*. There needs to be a small group of persons who went through a deep personal change and who could envision the same kind of change for the community. From

then on, they are ready to stubbornly stick to their dream, even in the face of being opposed and ostracized. That process has never been achieved in Aboriginal communities without a solid *spiritual belief* to give coherence to the project. It usually takes the form of a retreat in camps, rituals borrowed from other tribes or a form of meditation. Spirituality is important because there is the need to radically break with the past in order to be prepared to face the future. Breaking with the past here can mean detaching oneself from the fantasy of a lost paradise. For example, without healing someone becoming abstinent is still at high risk of getting hooked to video games in bars because the hope of the lost paradise is still the only thing that can lift him or her out of a depressed mood.

Spirituality in a very broad sense provides a community with a sense of pride or self-esteem, without which it could not come out of its state of perpetual crisis. This will be translated in the transformation of the public spaces with symbols of the culture, celebrations and rituals. In parallel, the hope of change will support initiatives and the organization of various groups and committees to face adversity. But, these initiatives cannot succeed if they are done in a vacuum, without interconnections. This has been repeatedly underlined in various reports, the need for all the actors, the band council, the school administration, the health and social services, and the security to cooperate in a joint effort.

Our last thought is an important aspect of resilience that is not uniquely related to the communities but to the Canadian society as a whole. Whatever the efforts done inside, a resilient process will be easier if there is openness and tolerance on the part of the wider Canadian society. There is still a strong attitude of racism that prevents the growth of pride and self-esteem in Aboriginal peoples. There is a huge effort to educate media and the political leaders in order to radically change the image of Aboriginal cultures. It is not only a question of image however. There are material conditions that plague these communities. Poverty, crowded and insufficient housing, lack of job opportunities, and security in the public and domestic spaces; all these factors are strong obstacles needing change. Healing can only do so much with regard to these basic needs. There is a necessity to rethink national policies regarding housing, employment, child welfare, and self-governance, and to bring together different levels of ministries and governments to find long-range and adaptable solutions.

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Community Resilience: Models, Metaphors and Measures

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ABSTRACT

In this paper, we discuss the importance of community resilience for Aboriginal health and well-being. The concept of resilience has been used in developmental psychology and psychiatry to describe individuals' capacities to achieve well-being and thrive despite significant adversity. Resilience is also a useful concept in ecology where it draws attention to the ability of ecosystems to adapt to environmental stress through transformation. The study of community resilience builds on these concepts, to understand positive responses to adversity at the level of families, communities and larger social systems. Despite historical and ongoing conditions of adversity and hardship many Aboriginal cultures and communities have survived and done well. In this review, we critically assess the various definitions of resilience as applied to individuals. We then examine resilience as applied to families, communities and larger social systems. We examine links between the concept of resilience and social capital. We then consider interventions that can promote resilience and well-being in Aboriginal communities. These include strengthening social capital, networks and support; revitalization of language, enhancing cultural identity and spirituality; supporting families and parents to insure healthy child development; enhancing local control and collective efficacy; building infrastructure (material, human and informational); increasing economic opportunity and diversification; and respecting human diversity. We also discuss methods of measuring community resilience, examining advantages and disadvantages to each method. Community resilience is a concept that resonates with Aboriginal perspectives because it focuses on collective strengths from an ecological or systemic perspective.

KEYWORDS

Community resilience, social capital, system dynamics, mental health promotion

INTRODUCTION

In the field of mental health, resilience is generally defined as a person's ability to overcome stress and adversity. Psychologists have often portrayed resilience as an individual trait. Recently though, there is increasing recognition that this individual-centered approach to resilience is problematic, because it lacks sensitivity to social and cultural context. A new body of work is attempting to expand the focus on resilience as a characteristic of the individual to one of resilience as a community and cultural process. This new focus on "community resilience" looks at how people overcome stress, trauma and other life challenges by drawing from the social and cultural networks and practices that constitute communities. At the same time, it draws attention to the resilience of the community itself.

Much recent work on community resilience has focussed on responding to environmental disasters like flooding, hurricanes, tsunamis, or earthquakes. While there are many aspects that are relevant to the concerns of Aboriginal communities, there are also fundamental differences. The adversities that Aboriginal communities face are not sudden, impersonal events like natural disasters but the persistent results of long historical processes borne of deliberate human actions and policies aimed at cultural suppression, oppression and marginalization. Unlike a disaster that disrupts or destroys existing infrastructure, many Aboriginal communities have undergone radical changes, displacements and reconfigurations in response to colonization and have had to improvise ways to cope with continuing marginalization and external control. As a result, rather than focussing on crisis responses to catastrophes, Aboriginal resilience must be considered in terms of the impact of structural violence, and interventions must take a long-term approach to rebuild, repair and revitalize community strengths and institutions.

The concept of community resilience has important implications for efforts to promote mental health in Aboriginal communities. Theories of community resilience are consonant with Aboriginal values that emphasize the importance of a person's relations with others and the environment. Aboriginal perspectives on resilience then lead us to think about the social-ecological networks that can reduce individual vulnerability and enhance well-being. These networks are embedded in and sustained by value systems that include notions of personhood, ethics, and religion or spirituality. Of course, there are many approaches to community resilience and not all fit with every Aboriginal setting. Each approach must be evaluated in terms of its relevance and applicability to diverse Aboriginal realities.

1.1 Outline

In this report, we explore a variety of current models and metaphors for community resilience that are pertinent to the diversity of contemporary Aboriginal contexts. We have emphasized those approaches that are consistent with Aboriginal values, that are relatively well developed, and that have some prospect of being measured in ways that can guide public health responses to community mental health needs and crises.

The concept of resilience is a technical term that has wide currency in developmental psychology as well as in ecology and organizational studies. There are many other terms that touch on similar concepts including strength, adaptability and hardiness. The common element is the ability of an individual, system or organization to meet challenges, survive and do well despite adversity. Resilience can occur at the level of the individual, family, community, nation, or global system as well as in ecosystems. The review addresses each of these different levels but focuses on the community level. We also address indigenous concepts of holism, which emphasize the importance of all sectors or dimensions of human experience in achieving balance and well-being.

Despite the appeal of the metaphor of resilience, there is a risk that the focus on resilience will reproduce the same biases and stereotypes that occur with discussions of risk and protection (Holton, Brass & Kirmayer, 2009). In particular, talk of resilience may lead to blaming individuals or communities as being somehow at fault for their own difficulties because they lack resilience. This ignores the complex web of factors that contribute to health and well-being. Instead, the construct of resilience aims to draw attention to positive aspects of adaptation that can be mobilized to improve outcomes. Resilience, however defined, is only part of the complex set of historical and current forces that influence the well-being and functioning of Aboriginal communities.

In Section 2, we trace the evolution and definition of the notions of individual resilience in both the published and "grey" literature. We briefly review work from psychology and psychiatry on resilience at the level of the individual. Understanding the characteristics of resilient individuals can help identify those features of communities that enable or facilitate individuals to thrive. At the same time, existing work on individual traits and processes provides ideas that can be applied by analogy to community resilience. In Section 3, we focus on "community resilience" in both the published and "grey" literature. The aim is to identify what is distinctive about communities that are "resilient" compared to those that are not. This, in turn,

points to both structural and process issues in the nature of Aboriginal communities.

Section 4 focuses on what is distinctive about resilience in Aboriginal contexts. We summarize the factors that appear to enhance or diminish resilience in different Aboriginal settings, with particular attention to history, scale, politics, and other factors that differ among communities.

In Section 5, we consider issues of measurement, outlining some potential indicators of community resilience that can be used to guide prevention and intervention and measure their success. Section 6 summarizes the implications of this review for interventions that aim to promote community resilience.

In Section 7, the conclusion discusses the appeal of resilience and outlines some of the broader questions that must be addressed to develop effective interventions. Appendix B provides some questions for further discussion and Appendix C some useful Internet resources.

1.2 Key Concepts and Terminology

The concept of community resilience brings together broad notions of resilience and community that function both as abstract concepts and as metaphors for a wide range of phenomena. In this section, we consider some definitions of resilience, community and community resilience. Other terms are defined in the Glossary (Appendix A).

1.2.1 Resilience

Resilience is a term derived from the physics of materials that has been applied in ecology, developmental psychology and psychiatry. In materials science, resilience refers to the ability of something to return to its original form after having been bent or compressed. This view from physics has a parallel in Eastern philosophy where the natural symbol for resilience is bamboo—the plant can be bent to the ground but will spring back, healthy and strong, and essentially unchanged.

In ecology, resilience refers to the capacity of an ecosystem to recover from environmental stresses like fires, drought, climate change, or pollution (Holling, 1973; Odum & Barrett, 2005). Ecological views of resilience emphasize the ability of natural systems to respond to a stress or challenge by self-correcting processes that restore pre-existing patterns and populations of plants and animals. Ecosystems show resilience through three broad mechanisms: buffering disturbances to reduce their impact, self-organization to maintain crucial system functions, and learning or adaptation (Abel & Stepp, 2003; Trospen, 2003). Often, however, ecological recovery does not involve a return to precisely the same original state but to a new

configuration in which the types of plants and animals and their relative numbers are changed to fit the new environment. In many ecological systems, therefore, resilience involves transformation: the system responds to a challenge not simply by restoring its usual form but by changing in ways that better fit the new environmental constraints. This notion of resilience as adaptation and transformation is crucial for psychological and social resilience.

In organismic biology, resilience refers to the capacity of the individual organism to respond to physiological challenges by restoring or maintaining bodily homeostasis or equilibrium. For ordinary fluctuations or small challenges, the body has mechanisms to restore balance; for example the level of blood sugar is maintained within narrow limits despite wide variations in our sugar intake from over the course of a day. When a stress exceeds the capacity of ordinary regulatory systems, set-points shift and other systems designed to deal with major challenges work to re-establish a new steady-state, a phenomenon called “allostasis” (McEwan, 1998). McEwan (2003) takes a developmental approach that assumes that each individual varies in (i) their “allostatic load” as a consequence of lifespan experience; and (ii) their ability to bear such a load. Allostatic load is a function of long-term stress and insult, and the individual’s ability to bear a heavy load depends on many personal and contextual factors. Again, as in ecological systems, this adaptation often means not simply a return to pre-stress conditions but a transformation of the system in ways that may lead to both specific strengths and vulnerabilities.

In psychology, resilience is generally defined as an individual’s ability to overcome stress and adversity. Personality psychologists have usually studied resilience in terms of individual traits or characteristics. Developmental psychologists have adopted a more interactional view, seeing resilience in the interactions of children with their caretakers or peers. Increasingly, however, researchers have critiqued these individual-centred models because they tend to ignore the larger social and cultural context in which individual development and adaptation takes place. A new body of literature is moving beyond the focus on individuals to consider the importance of social and cultural dimensions of resilience. This shift in focus is particularly relevant for Aboriginal communities, not only because of the obvious structural issues they face in response to the history of colonization (King, Smith & Gracey, 2009), but also because where indigenous notions of personhood, identity and well-being emphasize the interconnectedness of persons with each other and with the environment.

Any social grouping that forms a self-organizing or self-sustaining dynamical system in which different actors or

agents interact may exhibit resilience. At this abstract level, resilience is “the capacity of a system to absorb disturbance and re-organize while undergoing change so as to still retain essentially the same function, structure, identity and feedbacks” (Walker et al., 2002). Although different types of systems have different structures and processes, there are some general features of the dynamics of systems that are relevant to understanding resilience (Odum, 1994; Holling, 2001). To the extent that ecosystems, physiological systems and individuals share similar systems dynamics, ideas from ecology or biology may be used to understand psychological or sociological processes.

Fleming and Ledogar (2008a) discuss current definitions of resilience applied to Aboriginal research. A common definition is “adaptation despite high risk.” Other definitions include “good development despite high risk,” “competence under stress,” “recovery from trauma,” and “normal development under difficult conditions” (p. 8). Definitions of resilience require an element of adversity. For instance, some authors define resilience as “successful adaptation” in the face of “high risk,” “stressful experiences,” or “trauma” (Masten, 2001). Resilience often results in positive outcomes that are “beyond predicted expectations” (Richman & Fraser, 2001).

There are several important limitations to the resilience metaphor as it tends to be applied to Aboriginal peoples and communities. Resilience is seen as a process of returning to a previous state (“springing back”) rather than transforming into something new, as is more commonly the case. In psychology and psychiatry, talk about resilience tends to focus on internal characteristics of the individual rather than interactions with others and with the environment. Resilience is not a single entity or “essence” of the person but a name for the outcome of many processes. Many discussions of resilience look at specific traumas or catastrophic events rather than the persistent adversities that result from structural violence, racism and discrimination. Finally, and most importantly, in its emphasis on describing positive characteristics, the resilience metaphor tends to obscure the many tradeoffs that inevitably occur between risk and protective factors that are actually part of the same interacting system. All of these biases can be traced to a more general lack of attention to the social and cultural contexts that define adversity, positive outcomes, and adaptive strategies that contribute to resilience. Aboriginal values and perspectives emphasizing interconnectedness, integration and wholeness can provide an important counterbalance to the ways of thinking about resilience as discrete factors that tend to dominate current scientific writing.

1.2.2 Community

“Community” has many meanings and can refer to groups of people linked by common identity, geography, commitment, interest, or concern (Jewkes & Murcott, 1996). In an effort to clarify the concept of community, Christensen and Robertson (1980) suggest that a community consists of people, living within a geographically bounded area, involved in ongoing social interaction, and with psychological ties with each other and to the place they live. Although this definition fits the situation of rural and remote Aboriginal communities, it does not capture all of the meanings of community for Aboriginal peoples. The emphasis on bonds with others and with place is central to indigenous notions of identity and community. However, many Aboriginal communities arrived at their current form through processes of sedentarization, displacement or forced relocation, which continue to exert profound effects on community identity and dynamics. Some communities were established quite recently, and are built out of much older, smaller scale networks of families, clans or other groups. Other communities are derived from large-scale complex societies but, in the wake of colonization, have had to adopt new forms of governance, hierarchies and social structures. In most cases, current communities bear the traces of these earlier forms of communal life and this history adds layers of complexity to community resilience.

The importance of community reflects the fact that human beings are fundamentally social and usually live in closely knit groups. In the contemporary world, the idea of community also speaks to the feelings of isolation and lack of connectedness that many feel as a consequence of the shrinking of the extended family and atomization of society into individuals (Bauman, 2001). Some social scientists have critiqued the term “community” because it is often ideologically loaded and “tends to imply unverified assumptions about how people in small face to face groups are supposed to interact” (Tanner, 2008, p. 250).

There are enormous differences among Aboriginal groups depending on their original forms of social organization and ways of life, their historical relationship to colonizing powers, their geographical location, as well as their ongoing efforts to sustain and rebuild communities in the light of political challenges and new technologies. For example, Inuit “community” was originally based on the extended family unit, whereas some other Aboriginal groups lived in larger communities. The community as an historical entity therefore cannot be assumed to mean the same thing for every Aboriginal group. Indeed, the meaning of community has changed over time with changes in

living circumstances both locally and in interaction with the larger society (Allen, 1999). The challenges brought by colonization, residential schools, bureaucratic control, and other social, cultural and political changes may have different impact on communities depending on their pre-existing social structure, resources, strategies of adaptation, and consequent dynamics.

Although connections to the land or to specific places are an important aspect of indigenous identity for many Aboriginal peoples, communities are defined not only in terms of geographic locations but also larger networks that link people as members of First Nations, Inuit or Metis communities that may be geographically dispersed yet strongly connected through a sense of belonging. Many Aboriginal people move back and forth from a rural community to urban settings, while maintaining their sense of community membership. Others Aboriginal individuals are connected to an urban community or to one that is defined by shared historical experiences, cultural values, and political commitments and concerns.

Continuing social, political and technological changes are re-configuring Aboriginal community life. New forms of networking also have allowed new forms of community to emerge that are based on common interests and perspectives, or shared identities, that are facilitated by the Internet and other telecommunications rather than regular face-to-face interaction. This may be particularly important for youth who make active use of new technologies. Such networking also allows communities to form common cause and to find resources and share experiences in ways that may confer new types of resilience.

In this paper, we will use the definition of community provided by Christensen and Robertson (1980) as a starting point, remaining mindful that the term means different things in different contexts and is continuing to undergo transformation.

1.2.3 Community Resilience

The notion of “community resilience” has two interpretations:

1. It may look at how people overcome stress, trauma and other life challenges by drawing from social networks and cultural resources embedded in communities.
2. It may consider the ways in which communities themselves exhibit resilience, responding to stresses and challenges in ways that tend to restore their functioning.

Identifying the ways in which communities foster individual resilience can begin with analysis of the roots of individual resilience. The different factors that contribute to individual resilience can then be mapped onto those structures and processes of the community that promote, enable or enhance these individual-level factors. Resilience of the community itself involves the dynamics of the social response to challenges that threaten to damage or destroy the community. These dynamics may involve adaptations and adjustments of individuals, groups and organizations with the community (seen as components of the community as a system) as well as interactions of the whole community with its surrounding environment, including especially other social, economic and political entities.

1.3 Methodology

This report is based on a selective review of community resilience using online search engines (Google, PubMed and Psylit). We searched for all material addressing “resilience” and either “community,” “collective,” and Aboriginal, First Nations, Inuit, Metis, American Indian, or Alaska Native. From this we selected articles and reports directly addressing our core topic of Aboriginal peoples in Canada. This was supplemented with material on other Indigenous peoples, and specific issues, including: ecosystems, family systems, community response to trauma, measurement of resilience, social capital, and mental health promotion. Although the focus is on community resilience, we reviewed basic issues in individual resilience because of its importance for health and well-being.

2. MODELS AND METAPHORS OF RESILIENCE

Barton (2005) traces the evolution of concepts of individual resilience and shows how it began as a conceptual move away from illness, vulnerability and stigma towards a focus on strengths and assets. Initially, this involved identifying lists of personal traits, skills and resources that were viewed as independent factors that contributed to the individual’s resilience. The literature has moved from a “silo approach” of discrete or independent resilience factors towards an “ecological” view that focuses on the interaction of risk and protective factors. Resilience factors emerge at different levels: individual (psychosocial and biological), family, school, neighbourhood, and the macrolevel of social and economic structures.

Barton (2005) identifies several problems at the conceptual core of “resilience” theories. First, he argues that “resilience” is a culture-bound concept grounded in Euro-American and neoliberal discourses of choice, agency and flexibility. To go beyond this culturally bound or biased view, he encourages researchers to explore resilience in both general models and local cultural perspectives. Secondly, Barton points out that most definitions of resilience focus on it as a response to adversity. Yet resilience may also be shown in situations where hardship and vulnerability are not as apparent. Everyday challenges may also call for some of the same qualities of resilience that are seen in more difficult situations. Barton advocates a phenomenological approach to resilience that takes into account individual agency, situational context and processes of improvisation in everyday life.

On analogy to its use in ecology, resilience can be found at the level of families, groups, communities, and larger social systems. If many individuals in a community exhibit individual resilience, this can contribute to making the whole community resilient, since they work together more easily to respond to stresses and challenges. The link may also work the other way: a community that has resilient characteristics may increase the resilience of its individual members. This may occur in part because the community environment is conducive to healthy early child development but also because individuals can draw from community resources across their lifespan to meet new challenges. However, the interaction between individual and community resilience may not be so simple or exclusively positive. It is possible that certain aspects of resilience at the individual or community level may be in conflict with each other, involving tradeoffs of one aspect against the other. What is good for certain individuals is not always good for the community and vice versa. To consider this more complex possibility of trade-offs, we need to understand resilience at multiple levels. Before addressing community resilience, therefore, it is useful to consider the concept of resilience at the level of the individual.

2.1 Defining Resilience

In psychology and psychiatry, the concept of resilience emerged from clinical observations and research that recognized that many children do well despite very difficult childhood experiences (Luthar, 2006). In particular, some children whose parents have severe mental health problems nonetheless grow up to be well-functioning adults (Rutter, 1985, 2001). From this perspective, resilience is recognized as a positive outcome despite childhood adversity. Similarly, resilience was used to describe the success of children

living in harsh urban environments, exposed to poverty and violence, who nonetheless do well in school and grow up to be well-functioning adults (Garmezy, 1991). In adulthood, the resilient person is someone who lives a successful life as defined by such factors as steady employment, a stable marriage and overall well-being in spite of having been exposed to high levels of emotional, mental or physical distress (Lafrance, Bodor & Bastien, 2008). A large body of research has identified genetic and environmental factors that interact to confer resilience on the individual (Kim-Cohen et al., 2004).

In this view, resilience is an individual characteristic that is indicated by the person’s successful functioning; success is measured in terms of the achievement of specific social norms and roles (e.g. stable employment, relationships). The positive outcomes that provide evidence of resilience may be experiential or behavioural. Bonanno (2005), for example, defines resilience as an ongoing “capacity for positive emotions and generative experiences” during or following hardship (p. 136). Well-being, absence of depression or other symptom indicators may be taken as measures of individual resilience if the individual has a history of adversities that would usually lead to poor mental health. Behaviourally, resilience may be indicated by good performance in relationships, school, work, or other social roles. This makes it clear that social roles, norms and expectations are intrinsic to any definition and recognition of resilience. The strong normative aspect of resilience means it can only be defined in terms of specific cultural values and frameworks, and thus, may vary in different cultural contexts.

Even within developmental psychology, resilience has been operationalized and measured in diverse ways (Luthar & Brown, 2007). In many cases, resilience is defined simply as a positive health outcome in situations where an individual is exposed to risk, challenge or adversity. This raises the problem of how to separate resilience as a characteristic of the individual that explains past outcomes and predicts future responses from the outcome it is supposed to explain.

Disentangling resilience from positive outcomes is difficult. Strictly speaking, being resilient is not the same as simply doing well — a positive outcome depends on many other circumstances beyond the individual’s control. Faced with adversity, many individuals may show some negative effects. Resilience then would be shown by being “competent” or having normal capabilities despite exposure to severe or persistent adversities. Competence is defined in terms of the social demands and requirements at each stage of life and its meaning varies across the lifespan (Masten & Powell, 2003).

Resilience can refer to (i) a sort of strength, resistance or invulnerability that prevents the individual from getting sick; (ii) a capacity to heal, recover and return to functioning quickly and fully; or (iii) an ability to adapt, change course, and find a new way to live and go forward despite impairment. In terms of developmental pathways, resilience may involve maintaining a developmental trajectory, returning to the original trajectory after a temporary deviation or shifting to an entirely new trajectory that also represents a healthy life path (Luther, 2006; Masten, 2007).

The most common view of resilience in the literature is as a *positive adaptation in the context of significant adversity*. Situations of resilience are characterized by “successful outcome” rather than the negative consequences that would otherwise be expected (Rutter, 2007, p. 205). This implies (i) an exposure to threat or adversity and (ii) the achievement of positive adaptation despite major challenges on the developmental trajectory (Luthar, Cicchetti & Becker, 2000). Here “adaptation” indicates some combination of coping and growth or transformation despite chronic risk, stress, trauma, or catastrophe.

Of course, some measure of adversity is inevitable in every life. Ordinary challenges are central to the developmental process and may spur the individual on to greater health, strength and insight. Resilience is built not by avoiding stress but by facing stress “at a time and in a way that allows self-confidence and social competence to increase through mastery and appropriate responsibility” (Rutter, 1985, p. 608). In the case of more severe adversity, an individual may recover from a stress or trauma but carry a persistent “scar,” weakness or vulnerability related to the adversity they endured. In other cases, the experience of living through and overcoming a threat results in greater strength and mastery in the face of later challenges. This phenomenon also has been discussed in relation to more severe adversity in the literature on “posttraumatic growth” or “creative crises” (Rousseau & Measham, 2007; Tedeschi & Calhoun, 2004). Of course, both outcomes may co-exist, with strength in some areas and vulnerability in others reflecting the nature of the stresses and the strategies of adaptation.

In early work in developmental psychology and psychiatry, researchers defined resilience as a characteristic of individuals at high risk who have positive developmental outcomes. For example, a resilient child who has a parent with a severe mental disorder that disrupts their capacity to nurture, may nevertheless grow up to be healthy and high functioning. Similarly, children who do well despite experiencing extreme deprivation or abuse are said to display resilience. Because these situations are expected

to lead to negative outcomes, children who do well are viewed as exceptional. Their resilience may be attributed to constitutional traits and strengths, or to skills they acquire that allow them to survive and thrive in situations that seem to result in illness for most children. On this definition, resilience is an unusual characteristic of exceptional individuals. An alternative approach sees resilience as a common characteristic of healthy individuals, reflecting normal processes that promote positive adaptation despite stressful experiences (Konner, 2007). Masten (2001), for example, argues that resilience is not an unusual characteristic of exceptional individuals, but rather an ordinary process found in abundance in most individuals and populations.

Although many theories hold that resilience depends on exceptional social resources, such as a highly functional family, or community support, the way that people use these resources varies. Resilient individuals are able to use available resources to navigate through transitions and difficulties, whereas others may easily give up, become exhausted or deteriorate (McCubbin & McCubbin, 2005).

2.2 Resilience as an Individual Trait or Characteristic

Research in psychiatry and psychology tends to approach resilience as an individual phenomenon. From the 1970s, psychologists have continued to explore the individual qualities that enable people to deal effectively with adversity. Traits such as self-mastery, self-efficacy, positive outlook, and sense of humour have been isolated as contributing to resilience in the general population (Richardson, 2002). This work, much of which has focused on children, has also identified developmental processes that contribute to resilience, such as brain maturation, cognitive development, control of emotions, motivation for learning, and actively participating in social environments.

These characteristics and developmental processes may be viewed as residing within the individual or as fundamentally interactional, depending on relationships with other people. They may also be viewed as more or less “automatic,” emerging through normal development or as depending on adopting specific strategies through individual choice and agency.

Rutter (2007), for example, suggests that resilience largely depends on mental operations and mediating processes that reflect personal agency, idiosyncratic habits, coping mechanisms, mental sets, and the ways that people deal with challenges. In other words, an individual’s source of resilience lies mainly in their personal abilities and the cognitive strategies they use to get through adversities. For

example, a study of adults affected by severe trauma found that resilient individuals could enhance or suppress emotional expression according to context. These individuals “minimize the impact of loss while increasing continued contact with, and support from important people in the social environment” (Bonanno, 2005, p. 137). Those with “self-enhancing biases” were socially awkward but nevertheless effective managers of stress. Based on these results, Bonanno suggests that there are different types of resilience both in terms of pathways and outcomes; individuals may apply specific abilities to achieve different desired outcomes.

Similarly, Polk (1997) described four patterns or strategies of individual resilience: (i) the *dispositional pattern* is characterized by features of self-worth, sense of mastery and self-efficacy, as well as constitutional features such as intelligence, health, appearance, and temperament; (ii) the *relational pattern* reflects the person’s ability to seek comfort, support or inspiration from others; (iii) the *situational pattern* involves approaching circumstances using appropriate cognitive skills and problem solving abilities; finally, (iv) the *philosophical pattern* emphasizes the role of personal beliefs, the construction of meaning and self-knowledge in enhancing life experience. Polk believes that health professionals can shift people’s adaptive patterns by nurturing their inherent strengths and resources. Other researchers agree that resilience is a matter of individual adaptation, which though reflecting constitutional traits, can also be taught and learned (Bonanno, 2005).

2.3 Resilience as a Process

Resilience is a dynamic process that may vary from one social context to the next and from one worldview or value system to another. Resilience is not one thing or process. Different metaphors and models highlight aspects that may be relevant to individuals or communities in different settings or times. However, at a more general level, resilience reflects processes that draw from multiple sources of strength and resources to allow people to face, live with, manage, and overcome challenges.

Masten (2001) and others have argued that personality traits must be distinguished from more complex patterns of resilience. She suggests the contribution of personality traits be termed as “resiliency” while the dynamic process of competence can be described as “resilience” (Masten, 2001, p. 554). As Waller (2001) argues, the idea of static resilience is at odds with the human condition, since no one is resilient or non-resilient all of the time. Resilience, therefore, is better described as a process occurring through time, over a developmental trajectory, and in constant interaction with adversity and with changing life circumstances.

Luthar and Cicchetti (2000) note that recent research focuses on dimensions of risk and protective factors “that might *modify* the negative effects of adverse life circumstances and, having accomplished this, [identify] the *mechanisms* or *processes* that might underlie associations found” (Luthar & Cicchetti, 2000, p. 858). Burack and colleagues (2007) also discuss resilience as a process involving interacting protective and compensatory factors in an individual’s life. For example, supportive parents, employment and education might increase an individual’s level of protection, while the absence of such factors contributes to risk. A major challenge in this work is to describe the effect of these variables throughout developmental stages. Risk or protection at one stage, for instance adolescence, might affect a person immediately, or only later in life. In addition, ways of overcoming risks and drawing from protective factors used at one stage may not be adaptive or appropriate at a later stage. The significance of specific competences, challenges and relationships changes over the life cycle.

Resilience is not a simple linear causal process in which an abundance of strength leads directly to a good developmental outcome; instead, resilience involves interactions among multiple processes or strategies giving rise to alternate trajectories of development. These trajectories may be unstable, requiring constant input to maintain, or they may be self-sustaining. Resilience often involves tradeoffs, in which something is gained and something lost. Clearly, this makes it important to monitor the effects of any intervention carefully, measuring multiple outcomes to insure that desired effects in one area of a person’s life are not being achieved at the cost of another equally important concern.

2.4 Vulnerability, Risk and Resilience

Luthar and Cicchetti (2000) have distinguished between “risk,” “vulnerability” and “protection.” They use “risk” to refer to the broadest level of adverse life circumstance shared among a collective such as a community or neighbourhood, for example urban poverty. “Vulnerability” factors are specific adversities that exacerbate the effects of risk. Conversely, “protective” factors mitigate risk and bolster resilience. Vulnerability and protective factors can be found at individual, family and community levels.

Vulnerabilities of the individual could include poor impulse-control, or learning difficulties. Protective factors could involve a sense of self-efficacy or optimism. Vulnerability at the family level could involve harsh parenting or divorce, while protective factors could include

strong bonds of affection and good communication. At the community level, vulnerability might include neighbourhood violence and prevalence of alcohol use, while protective factors would include supportive relationships and frequent sharing of resources (Luthar & Cicchetti, 2000). Ungar (2008) has cautioned, however, that risk and protective variables cannot be divided clearly into levels of individual, family and community. Rather most vulnerability and protective factors work across levels, with implications for individuals, families and communities. For instance a sense of self-efficacy may be experienced by the individual but will also influence their capacity to provide support to others, and their contribution to community activities.

Most current work relates lists of risk and protective factors identified from epidemiological, clinical and developmental research in the general population to Aboriginal community resilience.¹ However, little is known about the mechanisms by which risk and protective factors work. A common assumption is that the effects of different factors is “additive.” Thus, a single protective variable, such as enculturation, can add to other protective factors, like perceived community support (LaFromboise et al., 2006) to yield a net effect of resilience. Other models recognize that risk and protective factors may be linked and interact creating situations of amplified risk or greater protection (Waller, 2001).

In addition to interacting with each other, risk factors interact with protective factors, which may also be thought of as resilience factors. In the *compensatory model*, the resilience factor is seen to completely counteract the risk factor (e.g. alcohol abstinence counteracts risk of alcoholism). In the *protective model*, the resilience factor reduces or buffers the effects of risk (e.g. family dinners mitigate the use of alcohol). In the *challenge model*, resilience arises from moderate exposure to risk; but the same resilience does not emerge in extreme (high or low) exposure to the same risk (for instance, a parent who uses alcohol moderately may positively influence his/her children; whereas excessive use may exert a negative influence) (Walsh, 2006). Thus, moderate-risk situations can, in certain cases, prove useful for developing resilience.

Some researchers have cautioned against constructing lists of risk and protective factors because these tend to reify resilience, implying it is a matter of fixed and deterministic traits. Further, the accumulation of risk and protective factors is not a simple, additive phenomenon (Burack et al., 2007). Rather, risk, protection and resilience are variable and dynamic. The inter-relations among risk and protective factors can be better appreciated through narrative and

phenomenological approaches to the study of development, coping and illness experience (Barton, 2005).

Ungar (2008) also urges researchers to be cautious when discussing categories of vulnerability or protective factors. Risk and protective factors must be understood and interpreted in local, and social contexts. A given factor may be protective in one situation, and confer vulnerability in another. For instance, academic performance has been shown to increase resilience in some Aboriginal youth (Strand & Peacock, 2003). However, in other cases education does not correlate with resilience outcomes (Carlton et al., 2006). In some Aboriginal communities, adults with more formal education who have few opportunities to make use of their skills may experience frustration, disappointment and distress (Kirmayer, Boothroyd, Tanner, Adelson, & Robinson, 2003; Duhaime, Searles, Usher, Myers, & Fréchette, 2004). Resilience may, to a large degree, be domain specific and involve tradeoffs (Iarocci, Root, & Burack, 2008). Thus, youth who do well in school may do worse than their peers in social relations. The potential for these sorts of tradeoffs means that resilience must be understood as multi-dimensional or, more accurately, as involving many distinct processes with potentially quite different effects on any specific outcome.

2.5 Family Resilience

Individual resilience may be strongly influenced by family process (Walsh, 2006). Families too have their resilience (Patterson, 2002). For McCubbin and McCubbin (2005), the defining outcomes of resilience are “adaptation” and “growth.” They see resilience as part of a family developmental transition involving “successful adaptation in the face of trauma if not catastrophic conditions” (p. 28). This leads them to distinguish between resilient and non-resilient families. Resilient families find a way through transitions and situational difficulties, and can “cope, adjust, adapt, and even thrive” despite hardship. In contrast, a non-resilient family tends to give up more easily or become exhausted.

Families have diverse responses to stress and there have been attempts to relate the models and typologies of family systems theory and family therapy to understanding resilience. Some of this work draws from studies of how families deal with stressors like war, illness, loss, life transitions, or dislocation (Boss, 2006; McCubbin & McCubbin, 2005). Family “protective factors” may increase prosocial behaviour and resistance to the negative effects of crises or stress by providing a stable yet flexible and supportive environment that allows for the “stability,

harmony and growth of family members” (McCubbin & McCubbin, 2005, p. 31). In contrast, a poorly functioning family environment leads to symptoms of distress, like depression or anxiety, and general inability to cope with trauma or other challenges.

From a family systems perspective, the family is a self-regulating system that interacts with a larger community, social system or ecology. The family must adjust its roles, goals, values, rules, and priorities according to external changes in order to achieve and maintain “balance and harmony.” The ability to “bounce back and transform” requires a range of competencies in the areas of communication, emotion, spirituality, community relationships, and more. Culture and ethnic identity can exert positive influences on family resilience. Culture helps families to make sense of change and is therefore “a source of stability and support, a way of dealing with the problems of daily life” (p. 32). Protective factors like cultural knowledge and practices enable flexibility and coherence, which are key components of both individual and family resilience.

2.6 Ecological or Systemic Resilience

Most psychological theories treat resilience as an individual phenomenon reflecting the constitutional and developmental experiences of the person. Resilience usually has been approached primarily as an individual characteristic even by community psychology researchers (O’Neill, 2005). This approach tends to downplay or ignore higher-level systemic and structural issues that may be the root causes of individual suffering and hold the potential for more effective interventions. This is a crucial issue for understanding resilience in indigenous communities, which continue to struggle with structural violence, systemic racism and other forms of adversity.

An increasing body of recent work within psychology, approaches resilience from an “ecological” perspective, in which individual risk and resilience are understood as being shaped by a dynamic environment. This includes individual’s biological and psychosocial experience, as well as the micro-social environments of family, school and neighbourhood, and the macro-level of social, economic and political processes.

To reflect this dynamic view, new metaphors have been developed to describe resilience borrowed from cybernetics and systems theory. For example, McCubbin and McCubbin (2005) describe the resilient system—whether an individual or family—as a sort of “thermostat” organized through feedback loops to seek and maintain a steady state. The individual or family system interacts with a larger social

ecology, resulting in adjustments in “roles, goals, values, rules, and priorities” according to external challenges in order to achieve “balance and harmony” (McCubbin & McCubbin, 2005, p. 29). The ability to return to a steady state or adapt by transforming the system requires a range of competencies that address communication, emotion, spirituality, and community relationships. Protective factors then are conceptualized in dynamic terms, resulting in adjustments to achieve “stability, harmony and growth” and serving as “a source of stability and support, a way of dealing with the problems of daily life” (McCubbin & McCubbin, 2005, p. 32). The ecological view emphasizes resilience as the ongoing maintenance of balance. The system itself (family or community) is responsible for achieving balance in response to changing contexts.

While ecosystemic approaches to resilience consider environments, they generally focus on how the environment affects individual resilience trajectories (Bogensneider, 1996; Luthar & Cicchetti, 2004; O’Neill, 2005; Waller, 2001). However, larger systems such as communities and societies can also demonstrate resilience (Sonn & Fischer, 1998), and interactions between levels (individual, family, community) contribute to resilience at each level. Rather than seeing individuals in isolation from their cultural, social and communal contexts, an ecological perspective also emphasizes the relationships within and between social systems, such as families, communities, societies, and cultures. Resilience is more than the sum of factors from each component. Each domain contributes new types of interaction with new dynamics. As Waller (2001) puts it, “resilience is a multi-determined and ever-changing product of interacting forces within a given ecosystemic context” (p. 290).

Fleming and Ledogar (2008) discuss how Aboriginal researchers have added a relational, cultural dimension to resilience by focusing on “traditional” activities in people’s lives, such as spirituality, healing practices and language. Healy’s (2006) definition of “cultural resilience” is useful in this regard:

The capacity of a distinct community or cultural system to absorb disturbance and reorganize while undergoing change, so as to retain key elements of its structure and identity that preserve its distinctiveness (p. 10).

In this view, resilience occurs through a dynamic interaction of individual and collective processes that contribute to adaptability, strength, the ability to surmount obstacles, meet challenges, and recover from setbacks.

3. COMMUNITY RESILIENCE

The ecosystemic view of individuals as embedded in a web of complex, interacting relationships has given rise to a new interest in community resilience. This work recognizes that resilience is a “clustered” phenomenon that is not randomly distributed among individuals in a society or community, but occurs in groups of people located in a web of meaningful relationships. The individual, family unit, community, and larger environment are interconnected, and factors from each realm contribute to processes that can counter stress and adversity. This perspective is shifting resilience research towards emphasis on collective processes, strengths and assets (Richardson, 2002).

This community perspective does not negate the importance of individual agency. In fact, research on community resilience advances the view that people can directly and actively harness their surrounding resources to foster healing. A resilient community provides individuals and families with new opportunities and resources to deal with challenges (Sonn & Fisher, 1998). The result may be quite different, and more effective, than what could be achieved by an individual or a single family acting alone.

Some approaches to community resilience emphasize the resources available to the community. Adger (2000) refers to community resilience in terms of the quantity and quality of resources accessible to the community and the extent to which these resources can be modified to meet new challenges. Breton (2001) suggests that community resilience is dependent on the stock of human and social capital within the community. Social capital, in this context, consists of people, networks and voluntary associations that can effectively mobilize individuals to action, as well as community services and infrastructure. In both of these conceptions of resilience a community’s strength is seen as residing in material and social resources. This lends itself to a relatively straightforward method of measuring resilience in terms of taking stock of resources and assessing the ease with which they can be mobilized and adapted to new challenges. However, it seems clear that the nature of available resources and their relevance to the community’s resilience will vary with other social and cultural factors, including the scale and structure of the community, cultural values and priorities, and relationships with the larger society and global systems.

In contrast to this emphasis on human and material resources, Clauss-Ehlers and Lopez-Levy (2002) suggest a conceptualization of community resilience as a process rooted in cultural values and practices. Based on work with Latino and Mexican youth living in the U.S., they consider

community resilience as consisting of three crucial factors: (i) obligations to nuclear and extended family members; (ii) the authority of community Elders; and (iii) the value placed on relationships in and of themselves as opposed to as a means to an end.

A resilient community is able to withstand internal conflict while maintaining the diversity of its individual members, families and groups (Sonn & Fisher, 1998). It also provides the capacity and resources for its members to cope with adversity. The social, cultural and psychological resources offered by Aboriginal communities are “alternative modes” to the mainstream assimilation model. In the indigenous context, what the authors call the “indigenous psyche” provides a counter-model and form of resistance against mainstream representations of Aboriginal people that serves as “identity protection” (Sonn & Fisher, 1998, pp. 458-460).

In work on how communities respond to disasters, community resilience is the capacity of a community or similar group to withstand, recover from, and respond positively to a collective crisis or adversity. On analogy to the different types of individual response to challenges, community resilience can take three broad forms that are not mutually exclusive²:

Resistance – the community may resist change, adjusting and adapting in ways that counter-act the impact of the challenge. A resilient community can withstand considerable disruption before undergoing any lasting change.

Recovery – with severe or prolonged challenges, the community is changed but after the challenges resolve, the community may work its way back to its original situation. A resilient community returns to its pre-disaster state more quickly than a community that is less resilient.

Creativity – a community may be transformed by adversity, developing new modes of functioning that take it along a new path. A resilient community can adapt to new circumstances and create new institutions and practices that carry its values forward.

As these terms make clear, resilience is a dynamic property of systems. A system may express resilience, insuring its own continuity, in ways that maintain its components but it may also transform or eliminate components. Thus, a community may express resilience that maintain its continuity and growth as an entity in ways that are distinct

from what is best for the individuals that comprise the community. Some individuals or groups within a community may be favoured while others are disadvantaged. This raises an important issue for considerations of community resilience: not all processes that serve the survival of the community as such will necessarily benefit all community members. Analysis of community resilience must always be considered in the light of the impact on individuals and the potential disparities experienced by some individuals or groups within the community.

3.1 Social Capital

Social capital is an umbrella term used to describe aspects of social networks, relations, trust, and power, either as a function of the individual, or as a function of a geographical location. Numerous studies have suggested that geographical units (ranging from small neighbourhoods to whole states or provinces) with “high levels” of social capital have lower suicide rates, lower overall mortality and longer life expectancy (Berkman & Kawachi, 2000; Kawachi & Berkman, 2001). However, Henderson and Whiteford (2003) have commented on the need for more refined theory and evidence for the posited links between social capital and mental health.

The concept of social capital was developed originally for thinking about urban or suburban communities but it has been extended to villages, neighbourhoods, networks, and other levels of social organization. Social capital can be defined as the degree to which a community’s resources (physical, symbolic, financial, human, or natural) are reinvested in social relations. Mignone and O’Neil (2005a) suggest that social capital is a potentially useful concept for First Nations communities for three reasons. First, social capital offers a dynamic metaphor for characterizing the internal and external relationships of communities. Second, it captures core social elements (e.g., sharing and reciprocity) that are important from a First Nations perspective. Finally, as a theory of the impact of the social environment, social capital can be linked to health outcomes (Baum & Ziersch, 2003; Crossman, 2008; Edmondson, 2003; von Kemenade, 2003a).

Social capital has several dimensions that vary across different types of communities. Mignone and O’Neil (2005a) outline the basic components of social capital, which include: social relationships, networks and reciprocity, shared norms and values, a culture of trust, collective participation, and access to resources. They formulate social relations in three ways: i) bonding relations, or intra-community connections; ii) bridging relations, or inter-community connections; and iii) linkage relations, or the relations between communities and governments,

institutions and other official bodies. Networks including these relations should be inclusive, flexible and diverse. A social network that is too rigid and exclusive can have a negative impact on mental health.

Whitley and McKenzie (2005) offer a critical perspective on the relationship between social capital and mental health. They note that the literature is still in its infancy and requires serious development, especially in relation to psychiatry. They suggest that social capital may not always be positive for mental health. For example, a “cohesive community... may be dependent upon homogeneity and obedience to social norms” (p. 79). Social capital may therefore be positive for some members and stifling for others. In addition to pointing to the importance of recognizing multiple dimensions of social capital and considering their benefits and drawbacks for different individuals or segments of a community, Whitley and McKenzie argue for the importance of a dual focus, on both vertical relationships (e.g., between communities and governments), and horizontal relationships (between communities of equal standing).

The concept of social capital provides a lens through which many aspects of community resilience can be viewed, since it focuses on social networks, in-group dynamics and relations with the wider society. Research suggests that social capital and social support are major determinants of individual and community mental health (Wilkinson, 2005; Wilkinson & Pickett, 2009). However, there are conceptual and methodological issues that limit the generalizability of existing work on social capital. Moreover, the dimensions of social capital that are important for Aboriginal peoples may differ from those relevant in urban multicultural settings due to their distinct history and contemporary experience (King, Smith & Gracy, 2009).

3.2 Social Networks and Social Support

Social networks refer to the nature and extent of linkages between individuals; these networks often include “strong” links to family and close friends, and “weak” links to acquaintances and colleagues. Social support refers to the emotional, material and instrumental assistance individuals receive (or can potentially receive) from other individuals both in everyday life and especially in times of crisis. Social support is often a function of the extent of social networks.

Social networks are the very stuff of community—the links between individuals and groups of people that are forged through a variety of practical, instrumental and emotional bonds.³ Social networks include families, friends, clans, work groups (e.g. businesses, co-ops, offices or groups of hunters), ceremonial, religious, recreational, and other community organizations. The size and scale of networks can

vary by community and are affected by many other social factors. In Aboriginal communities, extended families, clans and other traditional forms of linkage through mobility, trade and other activities all contribute to social networks.

Networks can provide material, economic, informational resources, assist with problem solving, and provide emotional and other forms of support in everyday life and in times of special need. Individuals are embedded in networks and these webs of relatedness, in turn, provide each person with social roles and statuses as well as common purpose and direction to their life. Giving to others through these networks may be just as important as being able to receive. Indeed, those who give to others are much more likely to receive in turn (Plickert, Côté, & Wellman, 2007).

Emerging research suggests the importance of the internet as a form of networking in some Aboriginal communities (Smith & Ward, 2000; Dyson, Hendriks & Grant, 2007). The role and impact of the internet as a contributor to social networks is an under-researched area. However, initial work suggests it can support existing networks and create new networks which provide people with some sense of identity and resilience.

There is a large literature documenting the profound mental and physical health impacts of social support and social networks (Berkman, 2000; Berkman & Kawachi, 2000). Much research suggests that social support and social networks can buffer the impact of crises, illness, trauma, loss, and other challenging life events, thereby protecting mental health during vulnerable times (Brown & Harris, 1978). Other research suggests that social support and social networks confer direct benefits in terms of better mental health and well-being. Social networks and social support also have a significant impact on physical health. Social support has beneficial effects on the cardiovascular, endocrine and immune systems (Uchino, Cacioppo & Kiecolt-Glaser, 1996). Conversely, loss of social support, through bereavement or social marginalization can have strong negative effects on the same bodily systems.

In a study with data from the 2001 Aboriginal Peoples' Survey Canada, social support was strongly associated with health (Richmond, Ross & Egeland, 2007). Four types of social support were examined: positive interactions, emotional support, tangible support, and affection and intimacy. For women, both emotional support and instrumental support were associated with better health, while for men only emotional support conferred this benefit. Social support is also one of the strongest predictors of positive outcome after exposure to violence or other forms of trauma (Charuvastra & Cloitre, 2008).

Of course, the same networks that provide social support may also stress the individual. The response of others to a

trauma can make it worse. For example, being rejected by others after experiencing rape can greatly intensify the impact of the rape (Andrews, Brewin & Rose, 2003; Hammack et al., 2004). So it is not only the density or richness of the social network but the types of relationships and emotional exchanges that determine the health outcomes.

Social support may also be associated with pressures, including demands for conformity and burdens of care or responsibility for others; these demands may be more intense in collectivist cultures that emphasize the value of the group over that of the individual (Kim, Sherman & Taylor, 2008). In such cultures, asking for help from others may be perceived as being burdensome and have negative effects on relationships. This may lead some individuals to restrain themselves in seeking help.

The types of social support available and their implications for the individual may vary by age, gender, social class, disability, and larger social structural issues, as well as by the individual's personality and specific health problem. For example, some communities may be rich in social support for older people, due to a high population density and an abiding respect for Elders throughout the community. This may be the situation for many Aboriginal communities. Other communities may see Elders as a burden, with older people being abandoned to their own devices. This situation is commonly seen in European and North American urban communities, which tend to valorize youth over age.

Theoretically, communities with strong social networks and social support should be marked by a high level of community resilience. However, making this inference requires a leap of faith, given that there has been little empirical work exploring the association between extent of individual level social support and community level resilience. In a landmark paper on "the strength of weak ties," Granovetter (1973) argued that extensive externally-focused weak ties are more important in terms of obtaining work, financial success and societal influence than intense and deep internally-focused strong ties. This builds on the work of Bourdieu (1986) who posited the importance of individual-level connections as determinants of economic success and well-being. The implication is that while interventions that enhance intra-community social cohesion may be helpful in increasing in-group social support and social networks, this should be accompanied by interventions that enhance linkages for individuals *outside* the community, as this allows for communal empowerment and influence on wider society.

3.3 Dimensions of Social Capital

Social capital is a broader concept than social support and social networks with multiple dimensions (Ferlander, 2007). The most common definition of social capital used in the health sciences originates with Putnam, which emphasizes the role of relationships, networks, trust, and norms. This definition arose out of empirical studies of the performance of regional government in Italy (Putnam, 1993). Putnam defined social capital as consisting of five principal characteristics, namely:

1. Community networks: number and density of voluntary, state and personal networks.
2. Civic engagement: participation and use of civic networks.
3. Local civic identity: sense of belonging, of solidarity and of equality with other members of the community.
4. Reciprocity and norms of cooperation: a sense of obligation to help others, along with a confidence that such assistance will be returned.
5. Trust in the community.

A key point of Putnam's work is that while social capital is often measured by gathering data at the individual level, its impact is collective, thus making it a qualitatively different concept from social support). For example, all individuals living in neighbourhoods where there are high levels of trust and civic engagement may benefit from these community characteristics—even the individuals who are suspicious of others and engage in no civic activity; any resident will be less likely to be a victim of crime and will be able to access a comprehensive social safety net in times of need, regardless of their individual contribution toward social capital. There is thus a complex relationship between individual- and group-level factors in social capital, which raises important questions about measurement, another issue of critical debate in social capital research. Most empirical studies in public health anchor the concept of social capital around levels of trust, community participation and community/individual networks. This transcends conventional social network/social support theory, which exclusively concentrates on an individual's social relationships as a variable of interest, by focusing on the role of group values and norms, rather than the characteristics of individuals. These values and norms, in turn, can be thought of as aspects of culture that influence both individual and collective identity.

One area of continuing debate, which much of the empirical and theoretical literature has not quite confronted, regards the question of whether social capital should be

conceptualized as primarily a property of neighbourhoods, groups and communities (ecological social capital), or primarily a property of individuals. While related, individual-level and ecological-level social capital may capture separate processes that differentially affect everyday experience—and, ultimately, individuals' mental health and well-being.

Although social capital was conceived of as an integrative concept with multiple dimensions, these dimensions may not all fit a given social context equally well. Accordingly, it may be more useful to think in terms of different types of social capital, recognizing that not all forms will be present or equally important in communities that vary widely by size, composition, history, and way of life. Such a conceptualization would reflect concepts of social support, which has often been divided into various types, for example the division between instrumental, informational and emotional support.

Uphoff (2000) defines social capital as consisting of two dimensions—structural and cognitive. Both *structural* and *cognitive* social capital are primarily conceptualized as properties of collective entities (e.g. neighbourhoods) rather than properties of the individual. Structural social capital is seen as consisting of relationships, networks, associations, and institutional structures that link people and groups together. These factors can thus be crudely measured numerically through an analysis of linkages and network density at a community level. This direct observation and enumeration will not be influenced by the perceptions of individuals within the sample, thus leading to some form of independent assessment. Cognitive social capital consists of values and norms of reciprocity, altruism and civic responsibility. Thus, cognitive social capital taps into shared patterns of cognition and subsequent social behaviour explicitly attempting to describe what Uphoff calls "collective moral resources."

As an extension of his previous work to address power relationships, Putnam (2000) formulated two dimensions of social capital: *bonding* (within group) and *bridging* (between group). Bonding social capital is inwardly focused and characterized by homogeneity, strong norms, loyalty, exclusivity, and a reliance on solid intra-group ties. Bridging social capital is outwardly focused, linking diverse groups and people; it is between groups and usually characterized by weaker ties.

Although the distinction between bonding and bridging social capital is theoretically interesting, it has rarely been empirically employed as a framework in studies of social capital and health. There are numerous questions regarding how this division could be used or measured. Furthermore though this distinction stimulates further thought regarding social capital, it still does not address issues of power and

structural inequality, which are inherent in alternative definitions of social capital such as that of Bourdieu (1986).⁴

Depending on their history, pre-contact social structure, and new configurations, Aboriginal communities may have different forms of bonding and bridging social capital. For example, some communities retain the complex social and political structures of families, clans and traditional leadership that provide lines of support in times of need. Other communities were created by forced sedentization or relocation of people who were traditionally organized in separate small groups. The larger communities have had relatively little time to develop new patterns of connection and social support and the fault lines separating different families or other groups are still present and may hamper solidarity within the community.

Woolcock (1998) argues that it is important to distinguish between social capital at the micro level, on the one hand, and social capital that maintains and provides institutional integration at the macro level. The distinction between micro and macro depends on the scale of the community and its relationship with other communities or larger social institutions. Colletta and Cullen (2000) formulate a similar distinction, describing social capital as consisting of two dimensions: *horizontal* and *vertical*. Horizontal social capital is defined as the number and extent of linkages between groups of an equal standing in society. Vertical (also sometimes called “linking”) social capital can be seen as the degree of integration and social efficacy of groups within a hierarchical society (including, for example, relationship with various levels of government). Vertical social capital can be used by entities such as Aboriginal groups to influence policy, to utilize and receive fair treatment from the legal system, and obtain resources from those in power. Woolcock (1998) argues that vertical social capital is a function of the organizational integrity, penetration and effectiveness of the state and, to a lesser extent, of the market.

In Aboriginal communities, vertical social capital poses a conundrum since the government organizations from which resources can be obtained are often the same institutions that have contributed to a community’s past, present and ongoing challenges (Samson, 2008). In addition, in many community contexts, the externally imposed (e.g. by federal or provincial government) vertical system does not coincide with traditional social networks and patterns of governance. Rather than mobilizing vertical social capital, the imposition of bureaucratically dictated structures of governance then undermines traditional forms of authority and solidarity. With these caveats, the concept of vertical

social capital can be useful for investigating potential sources of social capital and concomitant community challenges.

Colletta and Cullen (2000) equate horizontal bridging social capital and vertical integration with an inclusive, cohesive society. Through this definition of social capital, extra-community integration and social efficacy of groups are seen as being just as important as intra-community cohesion. This idea of vertical integration can have useful implications for deciding the kinds of interventions that would be appropriate and likely to obtain results in a certain social context. Efforts simply to increase within-group “community spirit” in an economically-deprived community, for example, by the building of new communal facilities, may be insufficient if the community still has unequal access to employment, education, lobbying power, and other important resources that may have an equal bearing on social capital. Additional attention may have to be given to re-structuring or forming vertical relations, such as the group’s relations with local government, employers, law enforcement agencies, and educators.

Rolfe (2006) explores connections between “ecological capital” and community resilience. She focuses on rural communities under stress. Her thesis is that ecological capital gives people options to “navigate and negotiate” social networks, which in turn, gives rise to “positive outcomes in community well-being” (pp. 3-5). To arrive at a definition of “ecological capital,” Rolfe draws on Hart’s (1998) conception of “community capital.” According to Hart, community capital is “the natural, human, social and built capital from which a community receives benefits and on which the community relies for continued existence” (as cited in Rolfe, 2006, p. 9). Similarly, *ecological capital* has four constituent domains. The first is “natural capital” -- the surrounding biological ecosystem, access to natural resources and natural services (i.e. clean air). The second domain is “human capital” – including skills, health, abilities, education, and the cultural values of community members. Third, “social capital” is comprised of bonds between individuals – in close and intimate relationships as well as across wider voluntary or institutional networks and organizations (Rolfe, 2006, p. 10). Finally, “built capital” involves roads, homes, equipment, and other human-made structures. The quality of relationships that emerges within the network of natural, human, social, and built capital is the total “ecological capital” of a community. Ecological capital also manifests as a sense of cohesion or “togetherness.” Rolfe describes resilience as a process, in which individuals and collectives “navigate and negotiate ecological capital... to sustain or improve community well-being” (p. 12).

3.4 Social Capital in Aboriginal Contexts

The vast majority of the research literature on social capital and health has focused on general population samples from the U.S., Canada, Australia, or Europe. Likewise social capital theorists have generally eschewed a detailed discussion of factors such as culture, race and ethnicity; instead taking a broad-brush approach to their conceptualization of social capital. Fortunately, a handful of scholars have recently taken the social capital concept and attempted to assess its utility in the Aboriginal context.

Mignone and O'Neil (2005a, 2005b) pioneered this approach in Manitoba. They worked with three communities in Manitoba, conducting in-depth qualitative research to identify dimensions of social capital to measure, and then used this list to create a questionnaire. The researchers eventually created a 99-item questionnaire and a 55-item short version to measure social capital in an Aboriginal context. Mignone suggests that this tool can be used to assess the strengths and weaknesses of a community, guiding and prioritizing subsequent policies. Their work led them to create the first framework of social capital that was grounded in the experience of First Nations people. This was done through a "concept analysis" of the qualitative data. This analysis led to an emerging framework dividing social capital into three dimensions useful for the First Nations context: (i) bonding; (ii) bridging; and (iii) linking (this last category is similar to "vertical social capital" discussed above). Mignone and O'Neil conclude that social capital in a First Nation community is based on the degree to which (2005a, p. 27):

- the communities resources are socially invested;
- there is a climate of trust, norms of reciprocity, collective action, and participation;
- the community possesses flexible and diverse networks that are include all members of the community.

Mignone and O'Neil (2005a, 2005b) have described plausible linkages between the components of social capital identified above and community level health, especially youth suicide. They argue that a community where more resources are "socially invested" will confer community-level protection against suicide risk factors such as hopelessness, lack of meaning to life, instability, and lack of control. Social capital and socially invested resources will manifest itself in stronger and self-confident communities with strong social networks and community pride.

The work of Mignone and colleagues is important for various reasons. It documents community-level characteristics that could be indicative of higher or lower

levels of social capital in Aboriginal contexts. These include conventional measures of social capital, for example trust and reciprocity. They also include characteristics more specific to Aboriginal communities. These include language revitalization programs and collective ceremonial or spiritual practices (for example sweatlodges or powwows). Their work takes the appropriate first steps to understand the cultural appropriateness of social capital in the Aboriginal context. The authors have created a culturally grounded framework based on in-depth qualitative methods. They have made plausible theoretical links between this framework and health, simultaneously creating an instrument to measure community level social capital grounded in empirical research. Their work suggests that the concept of social capital may be a very useful proxy for the measurement of community resilience among First Nations. Indeed, this position is taken by Ledogar and Fleming (2008), who argue that collective efficacy and social cohesion are key aspects of social capital particularly relevant to community resilience in Aboriginal contexts. Collective efficacy is important because Aboriginal communities have traditionally faced exploitation, racism and colonialism. Defending communities against these forces can be considered an important component of social capital and community resilience. New assaults on Aboriginal communities have come from global enterprises wishing to make money from Aboriginal communities. As such, bridging and vertical social capital is considered protective in that it can assist resistance to these external threats.

3.5 Summary

Community resilience has been discussed largely in terms of social capital and related constructs. Despite the diversity of approaches to the definition and measurement of social capital, there are a number of common themes and trends. First, most theorists agree that social capital is based on four main factors: networks, relationships, norms, and trust. Secondly, while some argue that social capital can be defined and measured as a property of an individual, others recognize it as a property of a social system or ecological unit such as a community. This social-ecological approach is found in the small body of work that examines social capital among First Nations (King, Smith & Gracey, 2009; Waldram, Herring & Young, 2006). Finally, a number of distinctions among types or dimensions of social capital have been made (e.g. cognitive, structural, bridging, bonding, horizontal, vertical) to fit the different contexts and social realities of communities.

Unpacking the notion of social capital can help with devising models and measures that can address the

great diversity of First Nations, Inuit, Métis, and urban Aboriginal communities. The challenge is to identify the dimensions of social capital that best fit the context of Aboriginal communities. Given their great diversity, it is likely that no single model will be applicable across all communities. Instead, we need a toolbox of constructs and corresponding measures that can be selected according to the characteristics of specific communities.

The contextual variables that will influence the appropriate model or dimensions of social capital include: (i) size or scale of the community; (ii) heterogeneity of the community; (iii) geographic location (urban, per-urban, rural, remote); (iv) history of the community, including whether it constitutes a longstanding social group or one newly formed under extrinsic pressures (e.g. relocation); (v) historical and current relationship to other Aboriginal groups and neighbouring communities; and (vi) cultural, social and historical values and norms influencing relationships with others within and outside the community.

4. COMMUNITY RESILIENCE IN ABORIGINAL CONTEXTS

Aboriginal people and organizations have found the concept of resilience useful because it focuses on strengths rather than weaknesses. Resilience theories emphasize the importance of family, community and culture in “countering the stresses that families encounter” (MacDonald, Glode & Wien 2005, p. 361). Culture and community can provide a sense of “mastery, self-esteem and ethnic identity” (p. 361). In an ecological, contextual or relational view, the individual, family unit, community, nature, and the spiritual world are interconnected. “Adaptation” is a process of balancing in which the whole of the person comes into play, including mind, body, spirit, and social-environmental context. The process of adjustment and finding balance draws resources from each of these domains. Resilience therefore involves holistic, complex, interacting relationships.

HeavyRunner and Morris (1997) outline some features common to many Aboriginal worldviews that may contribute to resilience. These include values, beliefs and behaviours related to spirituality, child-rearing, extended family, veneration of age/wisdom/tradition, respect for nature, generosity and sharing, cooperation and group harmony, autonomy and respect for others, composure and patience, relativity of time, and non-verbal communication. Each of these has expressions at the level of community as well as individual values, attitudes and behaviours.

Though there are certain shared and consistent elements to Aboriginal worldviews and values, it is important to recognize the wide variation in social contexts, cultural identity and spiritual practices across different First Nations, Métis and Inuit communities (Ledogar & Fleming, 2008). There are also significant cultural differences between communities in a particular region. Moreover, even within a community, individual and group processes involving culture, religion, spirituality, and community renewal can take different forms. Not all members of a given family, community or region will share the same spiritual or religious identity. Communities can contain this diversity within broader notions of identity and belonging.

4.1 Aboriginal Concepts of Health and Well-Being

Aboriginal approaches to resilience tend to consider the whole state of the person, describing well-being in terms of the balance of physical, cultural, emotional, and spiritual elements as depicted in the medicine wheel or other metaphors drawn from the natural world (Bartlett, 2005; McCormick, 2008). From this perspective, resilience is not an exceptional quality of some fortunate individuals, but the “natural, human capacity to navigate life well” (HeavyRunner & Marshall, 2003).

Many Aboriginal traditions have rich vocabularies to discuss healing and renewal, with multiple terms expressing “living well” (Adelson, 2000a; Gross, 2002) or having “strong will” (HeavyRunner & Marshall, 2003). Inner resilience is realized through a variety of practices encompassing spirituality, family strength, the role of Elders, ceremonial ritual, oral tradition, cultural identity, and support networks (Lavalley & Clearsky, 2006). Understanding resilience in Aboriginal communities requires attention to these indigenous conceptualizations of well-being, identity and “living a good life” that include dimensions of experience ignored or downplayed in categories derived from Eurocentric ways of knowing (Lavalley & Clearsky, 2006).

Lafrance, Bodor and Bastien (2008) discuss the congruence between Aboriginal worldviews and theories of resilience, especially in modern theories of childhood. The Aboriginal resilience framework emphasizes family, identity and cultural formation. Within Aboriginal frameworks, Elders must cooperate with youth to transmit philosophies, knowledge and principles within Aboriginal culture. Youth have the important role of making the transmitted culture workable in the contemporary economic, political and social environment. In the Aboriginal context, priorities for community well-being include: shared parenting and

community responsibility for children; emphasis on language as a source of renewed culture; knowledge of history and tradition as a key element of identity; development of traditional skills; emphasis on the importance of kinship and connection with one another; and spirituality and respect for nature. The authors identify similar emphases in modern resilience theory focusing on the child. According to resilience theory, protective factors for children include: one person who values and respects the child; contribution to the community; development of spirituality and identity; development of a talent or skill; and contribution to one's community. Resilience theory thus provides a way to "reconcile" important aspects of Aboriginal and western knowledge and values. However, despite their awareness of Aboriginal contexts, Lafrance and colleagues seem to define resilience quite narrowly in terms borrowed from Rutter (2001); truly engaging Aboriginal perspectives may require a shift in values and priorities of conventional models of resilience with corresponding community-oriented interventions.

There are important convergences between current thinking about community resilience and Aboriginal concepts of health and well-being. Aboriginal worldviews emphasize the interconnectedness of all beings with their environments. Indeed, human beings and the environment form one large interacting system. This systemic view that approaches each element or aspect of experience as related, so that changes are not simply additive but interact in nonlinear ways: a small change may have very large effects over time as it is amplified by the response of other parts of the system. Human agency is only one element in this dynamic system. In traditional systems of knowledge other forms of non-human persons and non-human agency are recognized. Thus, human beings have practical and moral obligations to maintain good relations with all aspects of their social, physical and spiritual environment.

There are parallels between indigenous notions of the person and ecological perspectives in developmental psychology and resilience theory. Aboriginal concepts of the person have been described as sociocentric, communalistic or relational, emphasizing the interconnectedness and interdependence of individuals within the family and community (van Uchelen, 2000). This relational self is balanced by a strong recognition of individual autonomy of thought, feeling and experience. In addition to this relational orientation, many Aboriginal cultures foster a sort of ecocentric self, in which the person is seen as strongly connected to the environment, the animals, plants, and forces of nature (Stairs & Wenzel, 1992; Kirmayer, Fletcher & Watt, 2008). Finally, many Aboriginal traditions emphasize a spiritual dimension to the self, in which the

person in transaction with a spirit world of ancestors, non-human persons or animal powers that influence human life.

This points toward the possibility of translating between the two knowledge systems or constructing a synthesis of indigenous knowledge and ecological science. The key tenets in this synthesis would include: a) reality is dynamic and constantly changing, as opposed to stable and consistent; b) adaptation is a key process in the relationship between humans and their environments; c) the process of adjustment and balancing draws on resources of the individual, family, community, and the natural and spirit worlds; and, d) resilience rests on the interaction and holistic interconnection of these spheres (Fleming & Ledogar, 2008a, 2008b; LaBoucane-Benson, 2005). An Aboriginal perspective would move resilience away from a simple, linear view of risk exposure, resilience and outcome, toward a more complex, interactional and holistic view. Aboriginal knowledge would add to resilience theory an emphasis on relational, cultural and spiritual dimensions. Culture here includes the role of traditional activities, such as spirituality, healing practices, and language in dealing with change, loss and trauma. Approaching resilience from Aboriginal perspectives can generate new and compelling models of wide relevance and applicability.

4.2 Historical Context

Aboriginal resilience must be understood in relation to the specific forms of adversity that Aboriginal individuals and communities have faced. These stem from the history of colonization, the unequal power and exploitative relationships that came with contact with Europeans, and the subsequent state machinery of regulation, control and active suppression of Aboriginal cultural traditions, community and autonomy (Kirmayer, Brass & Tait, 2000; Warry, 1998). Each Aboriginal community may face additional adversities specific to its history.

Duran and colleagues (1998) list six interconnected phases in the disruption of Aboriginal life in the U.S. that have close parallels in Canadian history: (1) first contact; (2) economic competition; (3) invasion and war period; (4) subjugation and reservation period; (5) boarding school period; and (6) forced relocation and termination period. These events have produced drastic transformations in Aboriginal life, involving loss of identity, trust, and connection to land and community (Hill, 2006). Historical losses and suppression of culture along with contemporary forms of marginalization and exclusion, including racism and discrimination, can interact with other vulnerability factors, such as poor parenting or health problems to increase the risk for a specific population or group. Each of these risk

factors do not operate in isolation; rather they are part of an interconnected web of factors that influence each other.

Many of the most severe threats to Aboriginal existence have come directly from government policies. The banning of sacred ceremonies such as the Potlatch and the Sundance suppressed cultural and spiritual systems of meaning. Policies of assimilation undermined Aboriginal languages and traditions and broke the transmission of traditional knowledge and childrearing practices. The residential school system dislocated nearly five generations of children resulting in enormous losses at individual, family and community levels. Euro-Canadian norms of the nuclear family portrayed Aboriginal families as unfit to provide for children and systematic out-adoption further disrupted kinship networks, confidence in parenting and the viability of the family as the core social institution.

Many writers have compared the Aboriginal experience to the situation of Holocaust survivors. Yet others have pointed out that the Aboriginal predicament differs because it involves significant ongoing oppression embedded in everyday routines and circumstances, including poverty, unemployment, discrimination, and health issues (Whitbeck, Adams, Hoyt, & Chen, 2004). As a result, resilience must be understood both in terms of response to historical trauma and loss, and to the ongoing challenges to Aboriginal identity and well-being.

4.3 Cultural and Community Protective Factors

Many Aboriginal individuals connect their sense of strength, safety and resilience to wider processes at social, cultural and community levels. For example, in recent interviews about resilience, Inuit elders from the Inuvialuit region emphasized spirituality, interconnectedness with others, and knowledge of culture and traditional practices as key protective mechanisms (Ajunnginiq Centre & Korhonen, 2007). Others have found similar mechanisms of protection following the themes of connectedness, spirituality, cultural knowledge, and tradition.

4.3.1 Family and Community Relationships

Families are the building blocks of community. They create the “nests” in which children grow to healthy adults and the support systems for adults and older people when they are ill (Ungar, 2004). A study of 120 Aboriginal youth from Canada and U.S. identified connections to parents, teachers, schools, and community as major contributors to resilience for youth (Bergstrom, Cleary & Peacock, 2003). Caldwell (2008) argues that more emphasis must be placed on primary or “upstream” interventions which create resilient youth. These interventions include improving parent-child

communication, encouraging daily activities that increase well-being, and fostering cultural and community ties.

In the past, policies of child protection and systematic out-adoption have threatened the continuity of Aboriginal communities (Blackstock & Trocmé, 2005). Carriere (2007) takes resilience as a starting point to reflect on adoption policy for First Nations children. She notes that First Nations children who are separated from family, community and culture face potential adverse effects as they negotiate their identity. Among her suggestions for government policy is the concept of “cultural plans,” which would help adopted children maintain contact with their First Nation community and culture (Carriere, 2007).

A disproportionate number of Aboriginal families involve grandparents taking care of their grandchildren (Fuller-Thomson, 2005). These “skipped generation” families reflect traditional patterns of shared childcare but are also a resilient adaptation to the impact of early pregnancies among youth. However, compared to their counterparts in skipped generation families in the general population, First Nations grandparent caregivers have more health problems, provide more hours of childcare and housework.

Resilience includes a “family’s ability to resolve transitional conflict caused by multiple stressors that they have endured and their successful navigation of subsequent transitions” (Landau, 2007, p. 353). Many Aboriginal people who show higher levels of resilience report that family and community ties are essential to their thriving (Carlton et al., 2006; Carriere, 2007). In a study of adolescent behaviour in mental health clinics, Landau (2007) observed that knowledge of grandparents was a predictor of lower sexual risk taking. Additionally, clients who knew and shared family stories, even those involving themes of vulnerability, displayed more protective tendencies than youth who did not. Landau concludes that adolescents from families that discuss themes of resilience generally show greater self-esteem than do their counterparts without such family learning about resilience.

Carlton and colleagues (2006) investigated multiple resiliency indicators in a comparative study of “high-risk” Hawaiian and non-Hawaiian youth. They asked about three levels of indicators: individual, family and community. At the individual level, physical fitness proved more influential for Native Hawaiians than non-Hawaiians in determining resilience. Academic achievement was less influential. At the family level, the support of relatives was significant in reducing psychiatric symptoms in the adolescents. Similarly, in a recent study, Silmere and Stiffman (2006) interviewed 401 urban and reservation-based Southwestern American Indian youth. Successful youth reported higher

levels of family satisfaction. Less successful participants on the other hand, reported a history of family abuse, living in a dysfunctional neighbourhood and friendships with misbehaving peers.

In a discussion of resilience, Inuit elders repeatedly emphasized the importance of connections to others as a source of resilience and a means of suicide prevention (Ajungniq Centre & Korhonen, 2007). In order to overcome hardship, they said, people must feel that others love and care about them. They also suggested that people must find opportunities to talk about problems and emotions so that negativity does not become overwhelming. Finally, the elders emphasized the importance of intergenerational communication in sharing coping skills.

Values associated with family and connectedness is reinforced by ideas from other domains of traditional knowledge. For example, Boss (2006) describes how Aboriginal notions of the cyclical nature of time and the human lifecycle enhance individuals' ability to deal with the challenges of caretaking a family member with dementia.

4.3.2 Oral Tradition and Storytelling

Stories and storytelling plays a central role in many Aboriginal traditions (King, 2003). Stories provide a way of talking about stressors and change that can enhance resilience (MacDonald, Glode & Wien, 2005). The narratives presented through stories have their origins in collective history, spiritual traditions and lived experience. They serve to link the generations, transmitting knowledge, values, and a sense of shared identity. The act of storytelling and listening itself is a way to connect people and create a sort of *communitas*—a lived sense of belonging and solidarity.

In Aboriginal communities, oral tradition reinforces social connections. Aboriginal languages often have specific terms that define the social relationships, roles and rules of conduct between persons (LaBoucane-Benson, 2005). Many relationships have a sacred aspect, involving harmony, cooperation, and periods of quietude, stillness and introspection (Heavy Runner & Morris, 1997). Aboriginal cultures also incorporate a tradition of oral storytelling which builds ties between family and community members and encourages moral and spiritual growth (King, 2003).

Denham (2008) refers to the oral tradition of teaching in Aboriginal families as a circle of learning and teaching in which the wisdom of ancestors guide current family members. Denham provides an in-depth analysis of how a Native family in Idaho uses narrative as a source of family strength. The family often discussed traumatic "risk" experiences, including the brutalities of colonialism and

current struggles such as racism and economic difficulties. Yet they reframed their narratives of trauma to promote resilience. The process involved connecting the personality traits, struggles and accomplishments of ancestors to current family and individual struggles. Through stories, the positive features of ancestors were captured in family and individual identity. Thus, past traumatic events were given significance and contributed directly to the construction and transmission of family identity. Families used a particular style of narrative "emplotment" in which narratives were fashioned according to a "strengths-based perspective" that highlighted the successes of family members in overcoming difficulties in traumatic conditions (Denham, 2008, p. 405). Stories emphasized learning and positive outcomes rather than failure or negative results. The narratives did not focus simply on events or manifest content, but showcased challenges, survival and persistence.

LaBoucane-Benson (2005) has also written on the way individual resilience connects to group and community resilience in such communal practices. Each member's skills, for instance, storytelling or drumming, help the family and community to adapt and function to support changes. Processes of collective sharing of stories allow for the transmission of protective features from individual to group. Traditional storytelling often employs humor to re-frame historical events and human foibles; this can mobilize a playful, creative, and open way of thinking and relating (Gruber, 2008; King, 2003). Sharing personal narratives also can work to enlarge the view of Aboriginal peoples in the mainstream society (Dion, 2009). This education and engagement of the public is an important process to insure that Aboriginal communities find a positive reflection in mass media and in their relations with other communities.

4.3.3 Connection to the Land and Environment

There is growing recognition in environmental studies and geography of the importance of place for individual and collective identities as well as health and well-being (Cosgrove, 2000; Gesler & Kearns, 2003). Research with non-Aboriginal peoples suggests that consciousness of the human relationship with nature may have benefits for both physical and mental health (Kaplan, 1995). This impact might be expected to be stronger for people whose lives and traditions have been linked to the land and the natural environment.

Indigenous people around the world have worldviews that recognize the links between place and health. However, notions of "place," "land" and "nature" have cultural specificities that must be taken into account to appreciate indigenous worldviews (McGregor, 2004). For most

Aboriginal peoples “the land represents more than just the physical or symbolic space in which people carry out their daily activities” (Wilson, 2003, p. 88). The Aboriginal connection to specific places is “fundamentally *interpersonal*” (Gone, 2008, p. 394). A study by Richmond and colleagues (2004) illustrates this idea, quoting a Namgis First Nation participant who stated, “the rivers and mountains and stuff are people in the family” (p. 356). At the same time, the land and the natural world constitute a larger encompassing reality of which the person is but one element (Kirmayer et al., 2008a).

The term ‘Land’ . . . is not restricted to the physical environment only. It has a much broader meaning, used by indigenous people to refer to the physical, biological and spiritual environments fused together. The closest scientific equivalent of the ‘Land’, taken without its spiritual component, is ‘ecosystem’ (Gleb Raygorodetsky in Gwich’in Elders, 1997, p. 14, cited in MacGregor, 2004).

In many Aboriginal worldviews, the environment is seen as constantly in flux, exposing the person to many challenges and disruptions that require constant adjustments (Robards & Alessa, 2004). At the same time, there is an assumption that life makes sense, that there is a higher or ultimate harmony or balance that can be experienced by the individual who attends closely to the natural world, including their experience.

In Canada, Aboriginal people clearly understand that their collective identity, health and well-being are intimately connected to their relationship to the land (Isaac, 2009). Knowing how to survive on the land and being able to maintain oneself and one’s family through economic activities associated with the land provides a path to develop and maintain self-efficacy and self-esteem (Richmond, 2007; Richmond et al., 2004; Wexler, 2006).

An analysis of data from the Cree Health Survey in Quebec found that spending time in hunting camps in the bush was associated with less psychological distress (Kirmayer et al., 2003). Ethnographic work found that community members frequently mentioned the psychological benefits of bush activities, which involve contact with nature, spiritual relations with animals, consumption of valued foods, and participation in traditional activities. Time in the bush was reported to increase family solidarity and social support, cultural identity and physical strength. Of course, the experience of connection to the land may also vary within a community by gender, age, and other individual and social characteristics.

Consumption of “country foods” is associated with feelings of health and well-being among Inuit, Cree and other Aboriginal peoples (Borré, 1991; Kirmayer et al., 2008a; Tanner, 1979, 2004). As well as the association between food, blood and mental well-being, connection to the land itself is viewed as having mental health benefits (Kirmayer et al., 1994; Therrien, 1987). This connection may be experienced and expressed through ceremonial and subsistence activities. A recent study with Aboriginal people in Australia demonstrated the health benefits of “caring for country” activities, including spending time on country, the seasonal burning of grasses, gathering of food and medicinal resources, performing ceremonies, production of artworks, and protecting sacred areas (Burgess et al., 2009).

Aboriginal perspectives on healing recognize this connection between the individual and the natural environment. Hardship and difficult emotions are considered part of life that can be mitigated through careful and considerate interaction with the land. The land provides ways to regain a sense of balance and well-being in difficult moments. In a study of healing in B.C., one participant stated: “[w]e were taught you go down to the river when you are stressed. . . I was taught by the elders that when you are blue and sad to go to the river and let the river draw that sadness out of you” (Strickland et al., 2006, p. 9). This very personal way of relating to place is also found in Wilson’s (2003) in-depth interviews with First Nations participants: “I talk to the trees and they listen. They take my problems away” (p. 90), and in the words of an Inuit elder discussing resilience: “[i]f you are at home being depressed and unhappy there is a place you could go – outside; that is the best place to take away bad things from your mind” (NAHO, 2006, p. 19).

For some urban Aboriginal people, many of these activities are now framed as “leisure” but their meaning goes well beyond that of other forms of recreation. Iwasaki and Bartlett (2006) describe how some Aboriginal individuals in Western Canada proactively cope with stress through culturally meaningful leisure activities. In Aboriginal cultures, leisure activities are located in a worldview that includes belief in the sacredness of all things, and reciprocal and interdependent relationships between human society and nature. Dance, music, sport, art, religion, and spiritual practices all emphasize engagement in a cyclical and ongoing pattern of life. Participants in the study noted many stressors related to health issues and social structural problems, such as lack of housing, poverty, discrimination, and political conflicts. Yet activities such as visiting the reserve, going out on the land camping or simply walking about, significantly relieved stress levels. Iwasaki and

Bartlett suggest that the process of protection in this case occurs in several ways. First, leisure activities emphasize interdependence and connectedness with others, reducing isolation. Secondly, leisure enhances cultural identity and satisfaction; and finally, leisure activities encourage spiritual and emotional growth.

The understanding that land and culture are inextricably bound together is important for maintaining cultural continuity in Aboriginal communities. Dominant societies have tried to erase the histories and geographies that provide the foundation for indigenous cultural identities and sense of self that are central to health in the indigenous worldview (Alfred & Cornthassel, 2005; Hudson-Rodd, 1998). Re-establishing expressions of indigenous identity that connect the land, the language, and the spiritual and cultural practices of a people may be vital to the resurgence of indigenous communities, and result in an increase in health and well-being (Panelli & Tipa, 2007). The land thus carries memories both of traditional ecological knowledge (TEK) and current political struggles (Feit, 2004).

4.3.4 Helping and Healing

Resilience may reside in the ability of individuals or communities to connect to effective and appropriate sources of help and healing. The renewal of traditional healing practices has been an important source of strength and identity for many Aboriginal individuals and communities (Gone, 2006, 2008; Kirmayer, Brass & Valaskakis, 2008; Waldram, 1997, 2008).

Some Aboriginal individuals may be suspicious of mainstream health services due to their association with exploitative and paternalistic approaches. The paradigm of resilience may prove useful in countering negative perceptions of mainstream services, framing interventions in ways that connect to Aboriginal cultural values (Fleming & Ledogar, 2008a). A focus on resilience encourages people to “navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being” by connecting with family, community and culture in meaningful ways (Ungar, 2008, p. 225). According to this perspective, resilience overlaps naturally with community level protective mechanisms to mitigate risk, dependency and destructive behaviour.

Many Aboriginal communities have a range of “natural helpers.” Natural helpers are ordinary community members who offer advice, support and comfort in times of need (Cross, 1998). A recent study by Waller and Patterson (2002) revealed the importance of natural helpers in a Diné (Navajo) Nation in Arizona. The authors found that Diné helpers were flexible in their approach, did not discriminate

based on their specific relation to the person in need, lacked expectations of reciprocity and provided instrumental support over an extended period of time. Waller and Patterson note that many community members often refer to natural helpers before they rely on professional helpers (such as social workers or doctors) for support.

Adelson (2000a, 2008) and Tanner (2008) have described how the Cree in Quebec created their own community “healing movement” drawing from a range of beliefs and practices. The healing movement incorporates three specific cultural and spiritual genealogies: i) Pan-Indian religious ideology, which includes collective practices such as Pow-wows, sweat lodge and pipe ceremonies; ii) Pentecostalism and its variations; and iii) local East Cree cultural traditions. Tanner shows how the three influences are sometimes merged or co-exist with certain tensions and contradictions in the Cree Healing Movement. For the most part, settlement-wide “Gatherings” mix knowledge, beliefs and practices – religious, non-religious, animist, and non-animist. There is a diversity of opinions about and forms of participation in the Movement. Some people, particularly some Elders, reject both pan-Indianism and Pentecostalism because neither relates to local East Cree cultural traditions. Yet Tanner describes the Healing Movement as a “local-level community building initiative” that contributes to collective support. He distinguishes the Healing Movement from mainstream therapeutic programs in three ways. First, the Movement is not concerned with tracing the origins of the social problems in the Cree communities to historical events and outside forces. Instead, the Movement focuses on those most directly concerned as being responsible for addressing the problems. Secondly, the Movement addresses problems not in the individual, but in the collectivity. Finally, the Movement is more than a therapeutic endeavour – it is a form of community strengthening.

Aboriginal attitudes toward illness and disability may encourage integration and support resilience in the family and individual (Boss, 2006; Connors & Donnellan, 1998). Infirmary and disability in Euro-Canadian value systems are often considered burdens because they affect economic productivity and drain resources. In contrast, Aboriginal notions of holistic care and healing do not always explicitly view individual illness as a sign of social illness; instead, the collective response to the weak and vulnerable is considered the prime indicator of communal health and well-being (Connors & Donnellan, 1998). In this context, it is the response to illness or disability, rather than the presence of illness or disability as such, that may be an indicator of resilience.

4.3.5 Spirituality and Ceremony

Spirituality has received increasing attention in the resilience literature. Aboriginal spirituality emphasizes several elements, including: interconnectedness with others; a sense of the sacred; efforts to renew oneself; balance and harmony; and desire for lifelong learning. In Aboriginal societies, spirituality is an important aspect of cultural strength.

Aboriginal spirituality may protect against alcohol use, the impact of discrimination, and suicide (Fleming & Ledogar, 2008a). A study in two Northern Plains American Indian communities found that strong cultural spiritual orientations (as indicated by endorsing statements on a question such as “there is balance and order in the universe,” “I am in harmony with all living things”) was associated with lower risk of suicidal behaviour than others to make suicide attempts (Garoutte et al., 2003). This benefit of spirituality persisted when age, gender, education, heavy alcohol use, substance abuse, and psychological distress were statistically controlled. A study in an Inuit community in Nunavik also found that frequent attendance at church was associated with lower suicide risk among youth (Kirmayer et al., 2003).

Spirituality may serve as a strong buffer against depression (Perez, 2008). In circumstances of high stress, such as the loss of loved one, serious illness, homelessness, or severe psychiatric illness, spirituality has been shown to significantly mitigate depressive symptoms. This may be because participation in a religious congregation or community provides social support. Religiosity and spirituality also tend to increase hope, positive affect, meaning making, and coping mechanisms while reducing negative feelings (Boehnlein, 2007). Individuals who report higher levels of religious or spiritual belief and practice are less likely to engage in risky health behaviours and generally engage in stable and positive health practices. The positive relationship between religiosity and physical health, and mental health holds even when controlling for variables such as gender, ethnicity, income, or education (Koenig, 2009).

Of course spirituality and religious identity may also be sources of conflict within families and communities. Different forms of spirituality and religious practice are available in most Aboriginal communities and individuals within the same family may have different levels of engagement or even follow different paths (Adelson, 2008; Tanner, 2008). Some traditions are critical of other paths, while some are more tolerant. Given the diversity in some communities, explicit values of tolerance and respect for individuals and for other groups may be important to promote a sense of solidarity and belonging despite differences.

Ceremonial activities such as the sweatlodge can be highly effective in forging a sense of connection to others in the community. Participants in a sweatlodge reported higher levels of self-discipline, self-actualization, caring for others, and sense of creativity after a ceremony (Schiff & Moore, 2006). Practices like the sweatlodge reinforce collective identity while providing participants with a rich, emotionally charged metaphoric language for transforming experience. For example, at one Southern Plains treatment centre, people with addictions attend a sweatlodge ceremony in which they visualize heat, rocks, wood, fire, and offerings as elements of cleansing and restructuring their lives (Bigfoot & Dunlap, 2006). Other ceremonial activities can also contribute to an embodied sense of identity and healing (Dion Stout & Kipling, 2003).

4.3.6 Cultural Knowledge and Identity

A prominent theme in studies of community protective factors is the importance of cultural knowledge and identity. It has been repeatedly shown that engagement with traditional beliefs and practices has considerable influence on Aboriginal well-being (Reynolds, Quevillon, Boyd, & Mackey, 2006). For example, a study of American Indian and Alaska Native students, researchers found that youth subject to stress exhibited resilience because they were “embedded in traditional culture” (Strand & Peacock, 2003). In this study, connection to tradition involved several characteristics, including: “feeling good about tribal culture,” participating both in Native and mainstream worlds, feeling a strong belonging to community, appreciating parents and Elders, and being exposed to a Native school curriculum. In a recent study of First Nations communities in Saskatchewan, McKay and Prokop (2007) found that children’s resilience was enhanced by a strong sense of belonging to a vibrant community that “celebrates its own culture and history” (p. 47). Tradition reinforces resilience through the values of belonging, mastery, independence, and generosity (Brendtro, Brokenleg & von Bockern, 2001).

In a study of health issues among Aboriginal women, Walters and Simoni (2002) observed that spiritual and cultural engagements like the sweatlodge ceremony and Native crafts contributed to positive “identity attitudes” in women, mitigating their negative health concerns. These traditional practices offer an “indigenist” alternative to mainstream health interventions and so participation affirms cultural identity. Adelson (2000) has also observed how indigenous communities foster vitality and renewal through the creation and promotion of pan-Indian identities, involving practices such as the powwow ceremony.

Others have defined enculturation in terms of people's identification to their culture, their sense of pride in their cultural heritage, and the extent to which they integrate their cultural heritage into their lives (Zimmerman, Ramirez, Washienko, Walter, & Dyer, 1995, 1999). Studies have generally shown that ethnic pride knowledge and practice of culture can serve as a buffer against stress and reduce negative health outcomes (Austin, 2004). For example, in a study of Anishinabe communities Whitbeck and colleagues (2004) found that enculturation, as measured by identification and by participation in cultural practices, tended to be associated with less alcohol abuse.

Identity tends to be seen as something defined by membership in a group, heritage or line of descent. However, identity is actively constructed by social interaction, narration, and embodied enactment. Identity then may be acquired by birth or by conscious choice, a distinction the Anishinabe scholar Gerald Vizenor (1999) calls, *natio* or *ratio*. In cultural psychology and medical anthropology, there has been a shift away from an essentialized view of cultural identity toward recognition of the negotiated nature of identity as self-fashioning and this has been applied to understanding Aboriginal identities (Gone, 2006, 2007; Waldram, 2004). Identity is embodied through lived experienced and narrated in specific social contexts, both of which depend on the nature of community. Identity also is supported by larger political struggles to assert collective rights (Niezen, 2003).

Gone (2006) discusses the complexity of American Indian identity. For example, some individuals assert an "authentic" Indian identity, based on blood quantum, language fluency or ceremonial practice. At other times "authentic" identity relies on "proof" of having been marked by the colonial experience, for instance by family alcoholism. Gone frames American Indian identity as a process of active "intentional construction" involving individual agency and both local and wider social influences. For this reason, Aboriginal identity cannot be approached as a single construct; rather, it varies depending on how people draw on cultural meanings and practices to make sense of their own experiences.

In urban settings, shared cultural practices may be more difficult to measure because people may have very different backgrounds reflecting differences in community affiliation, level of urbanization, cultural background, and education. Urban Aboriginal peoples are often dispersed throughout a city. Urban health providers often misidentify Aboriginal clients and make incorrect assumptions about their cultural practices (Macdonald, 2008). For all of these reasons, it has been difficult to conduct epidemiological research on

urban Aboriginal groups and there is little information available about their health status or other factors relevant to resilience.

Many Aboriginal people living in urban spaces are bicultural or multicultural; they may live or value a traditional way of life and they may be integrated to varying degrees into the mainstream culture or other ethnocultural communities (Clark, 2006; Sissons, 2003). Long and Nelson (1999) have shown that Aboriginal people living off-reserve in rural or metropolitan areas may be more consciously aware of tradition to maintain their cultural identity and affiliation whereas settlement/reserve-based Aboriginal people may participate in tradition without consciously articulating it as such. For individuals living in a remote community, many elements of tradition are embedded in their way of life; for urban Aboriginal people, many expressions of tradition must be actively sought and recreated. Measures of resilience must capture this diversity, which may differ within and between Aboriginal cultures and communities (Clark, 2006).

Aboriginal people often have multiple cultural traditions represented in their families, friends and communities. This may give rise to mixed or hybrid identities, with new values, attitudes and activities (Sissons, 2005). This diversity may also create tensions and contradictions that individuals must negotiate to maintain a sense of personal coherence, clarity and comfort with their identity (Brass, 2008). Resilience is also demonstrated by individuals who mobilize the strengths of multiple cultural commitments of the groups with which they are affiliated (Reynolds et al., 2006; Strand & Peacock, 2002).

The mental health consequences of multiple or hybrid identities depend, in large part, on the receptivity of the community. Traditionally many Aboriginal societies have been respectful of individuals' perspectives and small communities allow each person to be known by others in their individuality, in ways that go beyond stereotyping and may prevent stigmatization. However, communities may also demand conformity and have little tolerance for diversity. When a community feels stressed or threatened by divisive forces, there may be stronger efforts to re-assert a common identity and silence or suppress alternate perspectives and ways of being. Tolerance for diversity and explicit acceptance of some notion of pluralism in identity are important to allow individuals to find their place in the community (Niezen, 2005).

The pathways from cultural identity and knowledge to resilience and well-being are complex. A study of Southwestern American Indian youth living on reservation or in urban settings found that participation in American

Indian traditional activities actually correlated with less successful outcomes, including higher levels of substance use. The authors suggest this counter-intuitive result may reflect the fact that since youth often attend traditional activities with their friends, these activities may increase the likelihood of negative peer influences. Waller, Okamoto, Miles, and Hurdle (2003) have also argued that due to values of collectivism and non-interference in Aboriginal cultures, children who are pressured to use drugs or alcohol may have a difficult time resisting. It also may be more difficult to refuse drugs from family members than from other peers at school. Then too, being more visibly indigenous may expose youth to greater levels of racism and discrimination which may, in turn, have a negative effect on their coping and well-being.

These examples make it clear that cultural identity does not operate in the same way for all groups of youth; rather, the meanings and implications of culture specific to each context must also be taken into account. Thus, although culture can be an important source of strength and wellness for individuals and communities, it cannot be conceived nor applied as a “one-size fits all” solution. Careful consideration must be given to how historical, social, economic, and political realities affect specific and global cultural aspects in turn, impact community members and the community as a whole.

4.3.7 Cultural Continuity

A key element of resilience is the “persistence of identity” or a subjective sense of sameness over time, despite internal or external change. Identity persists because experience is continually integrated through language into meaningful sequences (Chandler, 2000). In this view, every individual is an author who reflects on the diverse episodes and events of his or her life and connects them to form a more or less unified story.

At the individual level, Lalonde (2006) describes two common cognitive strategies for maintaining identity: (i) identifying a stable underlying essence that remains the same over time and across situations; and (ii) constructing a narrative that links disparate aspects or versions of the self through descriptions of processes of change and transformation. Individuals (and cultural communities or traditions) may emphasize one more of identity construction more than the other. Those who “essentialize” tend to deny changes in identity, insisting on a stable personal core and those who “narrativize” foreground change while maintaining certain threads of continuity. In a study in BC, Lalonde found that Aboriginal youth tended to use the narrativizing style of identity construction. This style

may confer resilience in the face of rapid change as youth simultaneously reinterpret their external realities and find consistency in their internal worlds. According to Reynolds and colleagues (2006), resilience is apparent when a person is able to deal with contextual changes while maintaining identity factors, such as traditional values, beliefs and behaviours, with few personal or social difficulties.

Extending the notion of continuity of personal identity to the continuity of collective cultural identity, Chandler and Lalonde (1998, 2008) have conducted an important set of studies linking community indicators of health and well-being with community characteristics. They found that indicators of greater “cultural continuity” in the community were associated with better mental health, including lower suicide rates and school dropout rates. They define “cultural continuity” as a “workable personal or collective... mechanism” that reinforces “responsible ownership of a past and hopeful commitment to the future” (Chandler & Lalonde, 2008, p. 222). Originally, Chandler and Lalonde (1998) identified a set of indicators of cultural continuity including local (First Nation or community) control of education, police and fire, government, cultural centres, health, and social services. These were chosen partly for theoretically reasons but also because they could be readily determined by contacting a community representative. Most relate to the degree of control people exert over their “civic lives.” Subsequently the study was expanded to include a longer time period and more potential factors (Chandler, Lalonde, Sokol, & Hallett, 2003). The final set of factors found to be related included community efforts to: 1) secure legal title to traditional land; 2) establish self-government; 3-5) control local education, police and fire, and health facilities; 6) preserve and promote traditional practices; 7) involve women in local governance; and 8) take control of child and family services. The strongest effect on decreased suicide rates was with engagement in processes of self-government (which also strongly connected to the strengthening of traditional culture). The authors note that the “quest for self-determination” takes different forms depending on the community. For instance, in some communities success follows from renewing culture, while for others, priorities of land claims and education are more prominent. Collective means of preserving identity are linked to an individual process of coherence and continuity; both levels serve to mitigate suicide risk.

Extending this work, Hallett, Chandler and Lalonde (2007) found that among 142 BC First Nations communities, the preservation of indigenous languages had the strongest correlation with lower youth suicide rates, more so than processes of self-government, land claims,

education, health care, or cultural facilities. First Nations in which more than half the membership was fluent in their indigenous language experienced approximately 1/6 the rate of suicide of those without such language fluency. However, this effect of language may reflect the distinct context and variability of groups in BC. In other regions, language may not have the same predictive power. For example, there are very high rates of fluency and literacy in Inuktitut across the Arctic but many Inuit communities still suffer from high suicide rates. Similarly, several Quebec First Nations communities with good preservation of language nevertheless have high rates of social problems. Clearly, language can be a powerful source of resilience through its effects on strengthening identity, transmission of cultural knowledge and community cohesion. However, maintenance of Aboriginal language alone is not sufficient to protect communities from the effects of social adversity.

4.3.8 Political Activism and Collective Agency

Adger (2000) identifies a new focus in resilience research on the social, political and institutional mechanisms which determine resilience in relation to environmental change. He investigates the direct link between changes in ecological and environmental resources, and social resilience, using a case study of market liberalization and the privatization of mangroves in coastal Vietnam. He finds that social resilience in this community was decreased as privatization undermined common property institutions. Adger recommends focusing on several indicators of resilience in context of economic change: 1) Mobility and migration are significant markers. Labour mobility over time can point to either instability or stability in a population. Sometimes such moves can enhance resilience, and in other situations, relocation can have deleterious effects on communities in both sending and receiving areas; 2) Coping strategies used in a household or community facing economic and food insecurity, which can include voluntary or involuntary short-term adjustments, such as food choices, and other consumptive changes, or adaptation of income-generating activities; 3) Cultural modes of adaptation and local conceptions of human-environment interaction. The adaptation of a communal knowledge system, especially if it includes local technical knowledge, can counter larger lapses in trust generated by economic vagaries; and 4) Legal methods, such as maintenance of property rights are essential to resilience in a changing agricultural and economic context.

The evolution of resilience theory has paralleled changes in approaches to Aboriginal mental health that increasingly emphasized community empowerment, activism, autonomy

and control. These recognize Aboriginal persons as situated in current political realities that demand they balance traditional values with active negotiation and struggle for the authority and resources to direct their own lives and communities.

General discussions of identity tend to underemphasize the role of social action or collective agency in the production of well-being. According to Lavallee and Cleary (2006) resilience is not only about self-definition, but also about “self-determination.” Engagement in political activism and other forms of collective action can articulate, assert and solidify collective identity.

In their discussion of community level factors related to the prevention of suicide, Kral and Idlout (2008) argue that the concept of “social capital” is limited because it does not focus enough on social action, collective agency and control in the production of well-being. They suggest that programs that focus on community empowerment may resonate with Innuqatigiitiarniq, the Inuit perspective on mental health which focuses on the “healthy interconnection of mind, body, spirit, and the environment” (p. 318). Similar conclusions were reached in a comprehensive review of suicide prevention programs (Advisory Group on Suicide Prevention, 2003).

Chandler and Lalonde (2008) note that the “quest for self-determination” takes different forms depending on the community. For instance, in some communities success follows from renewing culture, while for others, issues of land claims or locally controlled and culturally relevant education are more prominent. For many communities, resilience has been fostered through programs related to promoting traditional healing and well-being. In some cases, these have been supported by government community wellness initiatives, in others by the Aboriginal Healing Foundation or local organizations.

Based on his experience with Innu communities in Labrador, Samson (2008) is more critical of the value of collaborative efforts between government and communities, arguing that government bureaucratic programs tend to undermine autonomy and self-determination. He suggests that resilience can be better achieved through Innu recovering their culture on their own by living on the land, speaking Innu and regaining traditional knowledge. Given the tendency for outside interventions to undermine local autonomy and control, focusing on personal and communal agency may be a more effective way to overcome the structural and social adversities that communities continue to face.

Of course, political activism or other forms of collective action are not always positive for every group in a community. In a study by Carlton and colleagues of native Hawaiain youth, community movements had relatively little effect on resilience among Native Hawaiian adolescents. In fact some community factors impacted resilience negatively. The authors suggest that the Hawaiian sovereignty movement may have generated communal divisions and other frictions that have negatively affected youth (Carlton et al., 2006). Communities that report greater cohesion and community participation—whether due to political activism, social movements or shared tradition—may also alienate some individuals through lack of tolerance for difference and diversity (Onyx & Bullen, 2000).

4.4. Summary

Theoretically, communities with high levels of social networks and social support should be marked by a high level of community resilience. Indeed, some approaches to community resilience emphasize the social resources available to the community as instrumental. Adger (2000) refers to community resilience in terms of the quantity and quality of resources accessible to the community. Importantly, he states that the extent to which these resources can be modified to meet new challenges is of prime importance. Similarly, Breton (2001) suggests that community resilience is dependent on the stock of human and social capital within the community. Social capital, in this context, consists of people, networks and voluntary associations that can effectively mobilize individuals into action, as well as community services and infrastructure. In all of these conceptions of resilience, a community's strength is seen as residing in material and social resources.

In fact, these resources are always in the service of particular individual and collective goals, aspirations or "life projects." Both everyday choices and larger political activities aimed at negotiating development must be understood in the context of these life projects.

Indigenous communities do not just resist development, do not just react to state and market; they also sustain 'life projects'. Life projects are embedded in local histories; they encompass visions of the world and the future that are distinct from those embodied by projects promoted by state and markets. Life projects diverge from development in their attention to the uniqueness of people's experiences of place and self and their rejection of visions that claim to be universal. Thus, life projects are premised on densely and uniquely woven 'threads' of landscapes, memories, expectations and desires (Blaser, 2004, p. 26).

Table 1 (next page) summarizes the community resilience factors identified in the general literature and those specific to Aboriginal communities. There is much overlap among these constructs and even those that are independent interact in many ways to amplify the effect of each other.

What is absent from this list are the larger factors affecting the larger society in which Aboriginal peoples live, both at regional, provincial, national, and international levels. These larger systems have a profound impact on the resilience of Aboriginal communities. Hence interventions aimed at enhancing resilience must also consider the broader society and global systems. Respect for Aboriginal cultures and autonomy in the larger society will contribute to conditions that enable individuals and communities to use their own resilience to maximum effect.

5. MEASURING COMMUNITY RESILIENCE

The ability to measure community resilience is important in order to recognize communities that are doing well, to identify factors or processes that may contribute to resilience and to evaluate the outcome of interventions designed to increase community resilience. Although various community level factors that contribute to resilience can be measured (including social capital, cohesion and ecological capital), resilience itself is difficult to conceptualize in ways that can be directly measured. In effect, resilience must be "inferred by the presence of positive outcomes in the social, economic, cultural and environmental health indicators of community well-being" (Rolfe, 2006, p. 12).

As previously discussed, there are a variety of definitions of community resilience. Each definition or conceptualization of resilience implies a different measurement strategy, ranging from assessing and aggregating individual-level data to the measurement of community-level institutions and activities (Harpham, Grant & Thomas, 2002). Each of the approaches has specific strengths and weaknesses; each approach captures certain aspects of community resilience, while missing other aspects of the concept. In this section, we review recent work on measurement of community resilience as well as making some suggestions to advance the field.

Norris and colleagues (2008) note several caveats to measuring community resilience. First, the advantages of particular resources may not hold across varying levels of analysis. For instance, "place attachment" may decrease resilience in situations of forced relocation, or it might actually increase the will of a community to rebuild after

Table 1. Dimensions of Aboriginal Community Resilience

Resilience Domain	Dimensions	Indicators/Measures
Social Capital*		
Bonding	Cognitive	Trust in others from same group Belief that community is close knit
	Behavioural	Membership in groups within community Number of meetings attended in last year
	Structural	Strength of ties to groups within community
Bridging	Cognitive	Trust in others from other groups Sense of personal safety
	Behavioural	Membership in organizations based outside community Number of meetings attended in last year
	Structural	Strength of ties to groups outside community
Linking	Cognitive	Trust in health care professionals Trust in community organizations Trust in different levels of government
	Behavioural	Political activism
	Structural	Number of contacts/meetings with government
Ecological Capital**	Social Capital	(As above)
	Natural capital	Quality of environment
	Human capital	Knowledge, skills, values, diversity
	Built capital	Infrastructure (housing, water, power, communications)
Aboriginal Cultural Knowledge, Values and Practices	Family and Community Connectedness	Support from relatives Intergenerational communication Positive parenting and family communication Strengths-based interactions in families
	Oral Tradition and Storytelling	Knowledge of traditional stories Community sharing of stories
	Connection to the Land	Participation in land-based activities Consumption of country food Caring for Country (Burgess et al., 2009)
	Healing Traditions	Number of healers or others with healing knowledge Frequency of healing activities Number of people participating
	Spirituality & Ceremony	Number of Elders or others with ceremonial knowledge Frequency of ceremonies Number of people participating
	Collective Knowledge and Identity	Number of different types and frequency of activities to learn, honor or celebrate collective knowledge and identity
	Cultural Continuity***	Local control of fire, police, education, social services, and other organizations Cultural heritage centers
	Political Activism	Land claims, self-government, involvement of community in challenges to development

* Adapted from Derose & Varda, 2009; ** See: Hart, 1998; *** Chandler & Lalonde, 2008.

disaster. Secondly, broad resources such as economic status or social security are not culture-neutral, but often culture-specific. Mechanisms for assuring social standing and class are often specific to tradition, such as degree of filial responsibility and other customs. Norms for social reciprocity and emotional and kin support can vary even within a culture. Third, the authors note that resilience is not an unchanging concept but a process that stems from changing resources. Resilience should not be used in new ways to stigmatize communities.

Before reviewing current strategies and available measures, it is important to consider the potential uses of such information by policy makers, public health workers and researchers. This primary purpose of measurement in this domain is to compare and contrast community resilience over time and across communities. Measuring community resilience over time can indicate the efficacy of interventions or policies designed to buttress community resilience. For example, health promotion interventions or language revitalization policies in Aboriginal communities may aim to increase community resilience. In this case, longitudinal research can measure community resilience before and after the intervention to assess impact.

The other main reason to measure community resilience is to compare data from different contexts, communities and circumstances. These comparisons can help identify specific components of community resilience. In some cases, Aboriginal communities can be compared with each other, or with other communities in the general population in order to identify the shared and distinct aspects of resilience. Several studies, for example, have compared the results of communities in different locations to each other; or Aboriginal participants to non-Aboriginal participants (Carlton et al., 2006; Kirmayer, et al., 2003; Schiff & Moore, 2006; Silmere & Stiffman, 2006). These types of analyses can help identify resilient communities and lead to a better understanding of the factors that promote community resilience. On the other hand, vulnerable communities can also be identified and offered appropriate interventions to strengthen resilience.

5.1 Aggregating individual-level data

One way of measuring community resiliency is to aggregate individual-level data to produce an average indicative of resilience at the community level. In other words, community resilience is approximated by evaluating and averaging community members' resilience. The average of individuals' resilience is used to represent the community's resilience. Such an approach can rely on data that is either (a) routinely collected through existing systems and

procedures, or (b) specifically collected for the purposes of assessing community resilience.

Whitley and McKenzie (2005) outline a number of methodological traps in measuring correlations between social capital and mental well-being that are pertinent to studies of community resilience. Studies that use measures from individuals face problems of individual bias. Individuals' state of well-being or distress influences their perception of the community. People who are distressed may not perceive social capital in their communities; on the other hand, an individual with relatively good mental health may report high levels of social capital. To get beyond this individual perception, it is important to canvas many individuals in a community and to use methods other than individual interviews or questionnaires, including participant and community observation.

5.1.1 Existing or routinely collected individual indicators

Existing or routinely collected indicators refers to statistics that are collected as part of ongoing policies and programs. In the Canadian context, these statistics are often collected at the community (e.g. municipality or First Nation Reserve), provincial and federal levels. Examples of routinely collected statistics include vital registration (births, marriages, divorces, and deaths), census data (each decade), health services utilization data, and public health surveillance systems (especially concerned with notifiable diseases). Crime and educational statistics are often routinely collected as well. These statistics are generally not collected by academic researchers as part of an academic program of research. They are collected by government agencies aiming to document and monitor secular trends as part of their routine business.

Aggregating individual-level data collected through existing systems is extremely efficient and a relatively low-cost way to assess community resilience. However, such data collection remains underdeveloped in Canada (e.g. Smylie, Anderson, Ratima, Crengle, & Anderson, 2006; Smylie & Anderson, 2006). As well there are several methodological limitations to using this type of data. First, there is wide variation in what is routinely collected depending on the province, municipality or Aboriginal community. Each jurisdiction also has different ways of defining Aboriginal identity. Some Aboriginal communities collect precise and publicly-available data on health outcomes. Others may be more circumspect in collecting and releasing statistics on sensitive outcomes such as suicide and depression. Second, some statistics are routinely collected, but are not publicly available and are difficult to access, for both the community

and academic researchers. Again this varies by geographic region and institution (Smylie et al., 2006). Third, definitions of key concepts may vary across databases. Suicide is an example in this regard, with research showing that in some communities suicides may be officially recorded as “accidental deaths” for religious or social reasons. Fourth, routine statistics are often only collected on certain key variables, which may be poor proxies for community resilience. Fifth, assessing the size and characteristics of the population itself may be difficult in communities where there is much fluidity, mobility and in/out migration.

The routine collection of standardized statistics would assist enormously in the assessment of community resilience in Aboriginal communities. Some of the suggestions below can only be implemented given an improvement in the availability of such routine statistics. However, every Aboriginal community is unique and should also be encouraged to develop locally customized and culturally meaningful measures of community resilience. Ideally, this process would allow for the generation of standardized data that can be validly compared across communities, as well as locally grounded data that can be validly compared over time.

In analyzing existing statistics for indicators of community resilience, researchers often focus on the following domains: (i) economic indicators; (ii) health indicators; (iii) educational indicators; and (iv) social and familial indicators. To be interpreted as measures of resilience such indicators must be compared across communities exposed to similar levels of adversity.

Economic indicators that can be utilized in this way include factors such as the per cent of able-bodied adults employed, average household income or levels of home ownership. This approach can gauge the economic well-being of a population and is often used to compare city neighbourhoods to assess need for urban regeneration programs. Poverty and unemployment are well-established determinants of health and well-being. Communities with high unemployment and low levels of income are often assumed to lack community resilience. However, this ignores other sources of meaning and value in the community including important unpaid activities (e.g. hunting, ceremonial activities, caregiving) and spirituality, which may contribute to community resilience. Economic indicators are often collected by the various levels of government, though they may be difficult to access. They can tell us something about community resilience, but must be appropriate for the context and can only give a partial picture.

Another common approach is to assess routinely collected health statistics as a proxy for community resilience. This often involves assessing the incidence or

prevalence of a given health problem within a community and then comparing these statistics over time or across communities. Most commonly, this is a mental health outcome variable collected by public health authorities or the coroner, such as deaths by suicide. Psychiatric epidemiologists may measure the extent of an outcome or risk factor, for example substance abuse or depression in the community. This is done through the administration of standardized measures such as the Beck Depression Inventory (BDI) (Beck et al., 1988) or the Center for Epidemiologic Studies Depression Scale (CES-D) (Somervell et al., 1992) of the K-6 (Furukawa et al., 2003) to a representative sample of a community. Results can then be aggregated and compared over time or to community averages and norms. Other health measures that may be used as proxy variables for community resiliency include life expectancy or per cent of people disabled.

Another common approach is to assess educational indicators as signs of community resilience. Commonly used measures include school retention rates or the percentage of students graduating from high-school. Again the availability of these statistics varies. Other measures could include percentage of individuals entering higher education or completing college degrees. Academic performance has been shown to increase individual-level resilience in some Aboriginal youth (Strand & Peacock, 2003). However, these indicators focus on formal schooling rather than education in its broader sense, and therefore do not capture the range of learning experiences important in Aboriginal communities. Aboriginal communities may place greater value on education by participation in traditional subsistence activities rather than “book-learning” in schools.

Social and familial indicators can also be aggregated to measure for community resilience. This may include factors such as the divorce rate, the number of single-parent families or rates of domestic abuse. Again, the significance of these depends on cultural configurations of the family, which may differ from Euro-Canadian notions of the nuclear family. Crime statistics can also be used as proxies for community resilience. Criminologists often divide crime into serious crime (for example murder, rape, assault) and “minor incivilities” which includes vandalism, graffiti and minor theft. These can be compared and contrasted over time and place as indicators of resiliency.

In the social domain, many of the factors discussed in the social capital section can be used as proxies for community resilience. These include levels of trust, community spirit, social support, and social networks. Again these data can be collected through self-report measures where individuals report subjective levels of trust or social

support using measures such as the Harvard University Social Capital Scale (Harvard University, 2002). These self-report measures are most effective if used in pre/post longitudinal studies testing the population impact of a population-level intervention.

5.1.2 Specific Measures of Individual Resilience

All of the measures discussed above are proxy variables that can be used to infer levels of community resilience. However some researchers have created instruments that deliberately attempt to measure self-perceived individual-level resilience.

This work includes interest in individual resources for dealing with chronic illness. For example, the “Brief Resilient Coping Scale” was developed to measure resilience in people with rheumatoid arthritis (Sinclair & Wallston, 2004). The scale consists of four items: 1) “I look for creative ways to alter difficult situations, regardless of what happens to me;” 2) “I believe I can control my reaction to difficult situations;” 3) “I believe I can grow in positive ways by dealing with difficult situations;” 4) “I look for ways to replace the losses I encounter in life.” Responses to this scale correlate with other individual attributes, such as tenacity, optimism, creativity, problem solving, and commitment to positive growth in difficult situations. People who endorse the items are likely goal-directed and successful in overcoming challenges (Sinclair & Wallston, 2004).

Another approach to measuring individual resiliency is based on research that suggests that “sense of belonging” or “sense of community” are linked to resiliency (Baumeister & Leary, 1995; Macintyre et al., 2002; Young, Russell & Powers, 2004). Davidson and Cotter (1986) set out to evaluate people’s “sense of community” which they defined as the “special attachment” between people and their social milieu in urban settings, by measuring people’s social motives “especially likely to produce sense of community.” The scale includes factors such as affiliation, control, safety, privacy, sense of urban aesthetic, and spiritual fulfilment. The authors envisioned these variables to be at work in social contexts such as the home, neighbourhood, government institutions, public services, religious venues, and recreational and educational sites. The goal of their scale was to make resilience a generalizable concept across cities—though, of course, such a technique may overlook important cultural differences in measurement.

While much of the work on measuring social capital has occurred in the general population in the U.S. and U.K., without reference to culturally specific factors, there have been efforts to develop measures that can be used internationally (Chen et al., 2009; De Silva et al., 2006; Grooteart et al., 2003). Mignone (2003) has developed

a guide to measuring social capital for First Nations communities.

5.2 Community-Level Indicators of Community Resilience

Communities are complex systems with emergent dynamics (i.e. they are more than the sum of the individuals they contain). Conversely, individual members of a community or group do not necessarily reflect the characteristics of the group. Both individual and collective processes require separate study and analysis because each level has its own properties and patterns of interaction or dynamics. Misattributing the characteristics of the group to individuals within it has been termed the ecological fallacy; incorrectly assuming that group level processes can be identified purely from individual characteristics has been called the “atomistic fallacy” (Diez-Roux, 1998).

Medical geographers, sociologists and epidemiologists have long argued that community-level concepts must be measured through community level indicators. This tradition has a strong theoretical and empirical heritage, and many creative researchers in these fields now use multi-level designs with complex statistical models to discern community level influence on health and well-being. This approach addresses the influence of structural factors on individual and collective well-being. As such, it avoids the tendency to “victim-blaming” that occurs with an exclusive focus on individual-level risk factors divorced from their social context (Holton, Brass & Kirmayer, 2009).

5.2.1 Existing or Routinely Available Community-Level Indicators

Von Kemenede (2003b) provides a useful review of community-level indicators of social capital based on available statistics. Some of these are not consistently available for Aboriginal communities.

One instrument currently being applied to First Nations across Canada is the First Nations Community Well-Being (CWB) index (McHardy & O’Sullivan, 2004). It combines several dimensions of social and economic well-being into a single indicator. Developed by Indian and Northern Affairs Canada (INAC) to assess the socio-economic well-being of First Nations, the CWB index uses data on education, labour force participation and employment, income, and housing from the Canadian Census to derive a single index score. Notably, data on other important aspects of life in First Nations communities, such as health, the natural environment and freedom from crime are not collected in a way that makes their use suitable in this index. Nonetheless, Cooke (2005) concludes that the

CWB is a valid measure of quality of life, it is sensitive to changes over time, and as such “will be a useful indicator of the well-being in Aboriginal communities” (p. 17).

In the past few years, INAC has attached the CWB index score to their published First Nation community profiles as a comparative indicator of “well-being.” The use of routinely collected data has allowed researchers to see if policy changes have had a positive effect on First Nations over a 20-year period. In an application of the CWB to census data from 1981 to 2001, O’Sullivan (2006) concluded that despite the gains made by First Nations in their index score, the gap between them and other Canadian communities remains significant. A comparative analysis of First Nation and non-First Nation communities concluded that there is something about First Nation communities apart from isolation and small size that is inhibiting their ability to achieve well-being levels seen in comparable non-native communities (White & Maxim, 2007). Although it only offers some insight into a portion of what comprises well-being in Aboriginal communities, the CWB does offer an important first step in understanding well-being. Furthermore, it may serve to act as a baseline when considering the effect of policy decisions and other attempts to address the disparities seen in Aboriginal communities.

The work of Chandler and Lalonde (1998, 2008; Chandler et al., 2003) is also relevant to the development of an index of a community-level resilience in Aboriginal contexts. Though the focus of their study was not community resilience, they identified six indicators of “cultural continuity,” which relate to the degree of control people exert over their civic lives: 1) securing legal title to traditional land; 2) establishing effective self-government; 3) gaining control of social services, including education, police, fire and health facilities; 4) preserving and promoting traditional practices; 5) involving women in local governance; and 6) taking control of child and family services. These variables all could be assessed by simple questions to administrators or consulting existing databases. In later work, they found additional indicators that could also be extracted from existing records, including the status and progress of legal actions over land claims, the proportion of women in government and the level of traditional language use in the community. This work has opened a very promising avenue for identifying community strengths related to cultural continuity, local control and empowerment. However, to date all of their work has been with BC First Nations. This work needs replication in other regions of the country to determine whether the same indicators work for communities with different histories, geography and social structure.

5.2.2 Developing New Community Level Indicators

Community level indicators that are truly distinct from individual measures depend on observations of community structure and process (Harpham et al., 2002). Lochner and colleagues (1999) have proposed a model for measuring overlapping ecological components of social capital (Lochner, Kawachi & Kennedy, 1999). They identify four constructs that can be used as indicators of social capital: (i) collective efficacy, (ii) psychological sense of community, (iii) neighbourhood cohesion, and (iv) community competence. However there is little agreement on the best way to measure these constructs.

The community development literature has also considered the issue of how to assess the level of community capacity or empowerment. Domains of community capacity include: participation, leadership, problem assessment, organizational structures, resource mobilization, links to others, critical awareness, and program management (Bopp, 1999; Lavarack, 2005). Each of these domains can provide a measure of the level of community empowerment (Lavarack & Wallerstein, 2001).

A recent scan of community resilience literature and relevant reports revealed the need for a tool that could help communities in identifying and increasing resilience factors related to the health of racial and ethnic minorities in their community, and in decreasing disparities experienced within these communities (Davis, Cook & Cohen, 2005). THRIVE (Toolkit for Health and Resilience in Vulnerable Environments), developed by the Prevention Institute, consists of twenty resilience factors in the four areas: built environment, social capital, services and institutions, and structural factors.⁵ The *built environment* is defined as a community’s infrastructure, including street design, public transit, places for incidental and recreational activity, the availability of affordable and healthfood, safe housing, clean air, water and soil, and in general, an inviting and culturally appropriate environment for people to be. *Social capital* includes “connections among individual social networks and the norms of reciprocity and trustworthiness that arise from them” (p. 27), as well as socially dictated standards for behaviour, which might regulate activities such as alcohol consumption. Social capital additionally involves networks of trust and cohesion, action on behalf of the community, collective and civic engagement, and shared norms. *Services and Institutions* depends on access to quality, culturally appropriate public and private services and institutions, including local government, health care systems, social services, education, public safety services, community groups,

community organizations, faith institutions, businesses, and arts institutions. In low-income communities the availability and affordability of these services is particularly key.

Structural factors are broader elements such as race relations, and employment and economic opportunities. When THRIVE was piloted in three American communities (rural, suburban and urban), in New Mexico, California and New York City respectively, several issues emerged as priorities across the sites: healthy, affordable food, shifting focus to the needs of youth and implementing more youth services and programs; and learning to deal with community diversity, for instance the influx of new migrants and cultural groups. While elements of this toolkit could be adapted to Aboriginal communities, there are unique aspects of Aboriginal culture, history and context not captured by this measures oriented toward culturally diverse urban neighbourhoods.

In a recent study of First Nations communities in Saskatchewan, McKay and Prokop (2007) found that individual-level child resilience was enhanced by a strong sense of “belonging to a vibrant, positive community that proudly celebrates its own culture and history” (p. 47). Factors that contribute to a vibrant positive community may include powwows, sweatlodges, longhouse activities, and extent of traditional ceremonies. The extent of traditional dance, music, sport, art, religious, and spiritual practices could all indicate a resilient and active community. Indeed, such activities are often measured by urban sociologists to gauge levels of social cohesion and community need. These are frequent variables used in the measurement of social capital. The number and frequency of these activities and the level of participation could be assessed as a potential measure of community resilience.

One aspect of Aboriginal communities where developing new indicators could be useful concerns spirituality. There are difficulties in assessing spirituality in general because the term covers an increasingly broad array of meanings (Koenig, 2008). Moreover, in assessing spirituality among Aboriginal people, it is important to remember that spirituality is often expressed in “everyday” activities, for example, in caregiving, hunting or consuming traditional foods. This is augmented by more specific sacred activities such as powwows, sweatlodges, smudge ceremonies, or in many cases conventional Christian worship. Spiritual orientation and activity can be measured at the individual level and aggregated to the community (Garoutte et al., 2003). This might include self-report measures of extent of engagement in spiritual or religious practices such as prayer or attendance at religious/spiritual ceremonies and rituals. Community-level variables can

also be measured that indicate scope and extent of spiritual practices. This could include the number of sweatlodges, healing circles or church services held within a community within a certain period of time. Self-report measures can then be triangulated with community-level measures to better assess the role and impact of spirituality/religion in the community under observation.

Another factor that could benefit from such an approach is language retention. Researchers can investigate language retention through self-report measures of who does and does not speak the language and of its use in other settings like local signage or media. However small numbers of speakers may not necessarily indicate a low resilience community; the community may have an active revitalization program in place that focuses on other aspects of culture.

5.3 Measuring Resilience in Aboriginal Contexts

Much of the adversity faced by Aboriginal peoples reflects structural violence⁶: inequalities in power, economic resources and social capital that reflect the legacy of colonization, forced assimilation and cultural oppression that Aboriginal people in Canada have faced over several hundred years.

The resilience of contemporary Aboriginal communities is a consequence of complex historical and social forces. As such, any attempt to measure community resilience must consider historical factors. Just as the developmental trajectory of the individual across the lifespan contributes to individual health and resilience at any given point, so do the dynamics of development influence the resilience of communities.

Historical changes in communities have reinforced some elements of community life while destabilizing, transforming or casting aside other aspects. Many of these historical changes, therefore, cannot be interpreted as simply positive or negative—they involve complex tradeoffs made for survival. Community resilience is not simply a matter of forging blindly ahead or of recoiling from threats and adverse circumstances, but a process of engagement, negotiation, creative adaptation, and active challenging of the evolving status quo.

Similar dynamics may be at play within communities. Qualitative research suggests that internal conflict within communities, can have a corrosive influence on community life and resilience (Adelson, 2002; Morgan Phillips, *personal communication*, August 10, 2009). Likewise friction and conflict between a First Nation and the wider geographic community can also have a detrimental effect on well-

being. That said the outcomes of conflict, rather than the presence of conflict per se, that is the prime determinant of resilience. Qualitative research on resilience in Kahnawake, for example, suggests that the “Oka crisis” galvanized the community, giving them a sense of purpose and increasing communal esteem (Morgan Phillips, *personal communication*, August 10, 2009). The types, extent and outcomes of both internal and external political conflict again could be enumerated as a potential indicator of community resilience.

The legacy of the residential school system continues to have a profound impact on Aboriginal health and well-being (Stout, 2003). However, Aboriginal communities were differentially affected by the residential school system. Some communities lost a greater proportion of children to residential schools than others. Recent research suggests that attendance at an Indian Residential School is associated to distress not only among those who attended, but also their descendents (Bombay, Matheson & Anisman, 2009). The intergenerational transmission of trauma can occur both through family interactions and larger communal processes (Kirmayer et al., 2007; Serbin & Karp, 2006). The transgenerational impact of residential schools may depend on the proportion of parents in the community influenced negatively by these experiences, and the availability of alternative resources to support effective parenting and positive family life.

Whitbeck and colleagues (2004) devised two 12-item scales to measure the effects of historical trauma among American Indian individuals in the Midwest. They originally developed the scales through extended focus groups with Elders and other Indigenous individuals on reservations. During focus groups the participants were asked to share their ideas of loss. The authors extracted the most frequent themes from discussions and incorporated them into the *Historical Loss Scale*. They also developed a second scale, the *Historical Loss Associated Symptoms Scale* as a measure of the emotional responses triggered by the thought of the losses. The Historical Loss Associated Symptoms Scale could be viewed as a measure of how individuals have emotionally coped with and managed past and current losses. Although not a direct measure of the resilience process, it can approximate individual’s emotional resilience to collective adversity.

Using constructs like resilience across different cultures and communities raises issues of the equivalence of meaning and measurement. Burgess and Berry (2009) urge researchers to develop Aboriginal-sensitive measures. In some instances, scales administered in English may not accurately reflect indigenous conceptions of health, illness or resilience. Even where English or French are the languages of everyday life, Eurocentric categories can confound

results. For instance, in Aboriginal community contexts, the category of “income” on scales and questionnaires should include forms of subsistence production, and “education” should include traditional knowledge. Future studies might broaden definitions of successful functioning by examining other outcomes that are valued by Aboriginal youths and their communities (Silmer & Stiffman, 2006). Attention must also be paid to developing specific definitions of terms such as resilience or spirituality so that they are sensitive to Aboriginal conceptions. In a recent study, Schiff and Moore (2006) wanted to assess how spiritual elements of the sweatlodge translate to emotional well-being. They began the study with few available, relevant models. No existing instruments connect the two variables in context of a holistic, Aboriginal framework. In the absence of an ideal instrument, the researchers combined two questionnaires, the SF-36 and The Heroic Myth Index (HMI), for the purposes of the study. The SF-36 is a multipurpose health survey that provides a general measurement of physical and mental health. The HMI is a scale, based on Jungian psychology, that consists of 72 items reflecting various personality archetypes (innocent, orphan, warrior, caregiver, seeker, destroyer, lover, creator, ruler, magician, sage, fool, etc.). Schiff and Moore noted that Aboriginal participants seemed to dislike the SF-36 scale because of its limited, objective-style response options. Some participants had even written an “X” next to questions to indicate dissent. The HMI scale was better received, possibly because it involved more fluidity of response. It also avoided notions of deficit and focused more on strengths and resilience.

The deficiency of existing instruments is often compounded by a more basic problem termed the category fallacy (Kleinman, 1977). The category fallacy refers to the uncritical imposition of categories and constructs developed in one culture on another culture. Some of this can be seen in the social capital literature. For example, electoral turnout is often considered a valid measure of a community’s social capital. However, research suggests that in some active and presumably resilient Aboriginal communities, segments of the community may boycott Council elections as these are considered externally imposed governmental institutions. In this context, electoral turnout may not be an indicator of communal resilience. In fact, in the example just given, it could be the complete reverse: lower levels of participation in Council elections could indicate more cultural continuity, which as discussed above has been linked to community resilience. Qualitative research exploring the local meanings of potential indicators is essential to develop valid measures of resilience (Adams, Madhavan & Simon, 2006; Canino et al., 1997; De Silva et al., 2006; Ungar, 2004).

5.4 Summary

We have described measures of community resilience based on an aggregate or average of individual reports and on indicators of community organization and functioning. Using both methods provides a form of triangulation that strengthens the validity of any inferences made. This approach is advocated by Ungar and colleagues (2005) who argue that resilience can be best understood as an interaction of individual capacities and structural conditions, which are closely related to social, political and economic assets.

Developing appropriate indicators of community resilience can follow three basic steps:

1. Decide how to conceptualize resilience; what is the local definition of community resilience in your context (e.g. vitality of language and culture).
2. Determine which indicators/variables speak most strongly to this definition, and how they interpreted to represent community resilience (e.g. language use and cultural events).
3. Decide how to best measure the indicators (e.g. interview people on their use of language or count language teaching programs in the community); count number and frequency of cultural events in the community and level of participation).

Although it is intended to have predictive value, identifying communities that will do well in the face of new or continued challenges in the future, resilience is usually measured by evidence of having already done well despite past adversity. Only a well-established model of resilience that documents the value of certain indicators can allow the confident use of those as markers of future response. Promising indicators relevant to the historical context of Aboriginal communities have been identified but much more study is needed to insure these are applicable across diverse communities. As well, since resilience is not a fixed trait of individuals or communities but a dynamic response to changing circumstances. Research must therefore be attentive to the fluctuations of resilience over time.

6. PROMOTING COMMUNITY RESILIENCE

The key question from the point of view of health and well-being is how to increase, promote and maintain resilience in Aboriginal communities. Many types of intervention directed at individuals and whole communities may contribute to the development of community resilience (Richardson, 2002).

As discussed in Section 4 of this report, HeavyRunner and Morris (1997) outline some features common to many Aboriginal worldviews that may contribute to resilience. These include: values, beliefs and behaviours related to spirituality, child-rearing, extended family, veneration of age/wisdom/tradition, respect for nature, generosity and sharing, cooperation and group harmony, autonomy and respect for others, composure and patience, relativity of time, and non-verbal communication. This list overlaps with that developed in recent research with Inuit elders in Nunavut, who emphasized spirituality, interconnectedness with others, and knowledge of culture and traditional practices as sources of resilience (Ajungniniq Centre & Korhonen, 2007). Tanner (2008) found that sources of well-being recognized by James Bay Cree included: shared parenting and community responsibility for children; emphasis on language as a source of renewed culture; knowledge of history and tradition as a key element of identity; development of traditional skills; emphasis on the importance of kinship and connection with one another; and spirituality and respect for nature. Others have found similar sources of resilience emphasizing themes of connectedness, spirituality, cultural knowledge, and tradition (Lavallee & Clearsky, 2006).

As can be seen from this brief summary, the themes that commonly occur as potential areas of action to promote resilience in Aboriginal communities are varied but center on factors such as cultural practices, tradition, spirituality, interconnectedness, and respect for land. Potential domains for action are listed in Table 2. Intervening in these broad domains may be the best strategy for enhancing community resilience. In briefly considering these domains, we will refer to examples of culturally sensitive prevention or resilience promotion programs with Indigenous populations that have been studied or documented (Ellis, 2004; LaFromboise & Lewis, 2008; Waller, Okamoto, Hankerson, Hibbeler, Hibbeler, et al., 2002). These prevention programs focus not just on reducing risk, but also on promoting protective factors which include resilience (Bogenschneider, 1996).

6.1 Revitalizing Language, Culture and Spirituality

Language, culture, spirituality, and ceremony are thoroughly intertwined in many Aboriginal communities. It has been repeatedly shown that engagement with traditional cultural beliefs and practices has considerable influence on Aboriginal well-being (Reynolds, Quevillon, Boyd, & Mackey, 2006). Walters and Simoni (2002) have written of the way Aboriginal women draw from indigenous cultural resources to combat stress and negative health effects. They discuss the importance of “enculturation,” the processes by

which individuals learn their own culture, as a buffer against stress and negative health outcomes. Such work is consistent with other work on ethnic identity which indicates a strong cultural and ethnic identity is good for health and subjective well-being.

Renewing and promoting traditional cultural beliefs and practices may enhance community resilience. Pilgrim, Samson and Pretty (2009) describe six main types of cultural revitalization interventions; these are centred on: (1) reviving traditional methods of food collection and preparation and increasing the consumption of traditional foods; (2) reviving traditional cultural practices and ceremonies as part of income generating through ecotourism; (3) providing culturally-appropriate and locally controlled education; (4) protecting and promoting the use of traditional language (which serves to reinforce the connection between Elders and youth); (5) maintaining or reinstating cultural knowledge and practices that have been suppressed, displaced or forgotten; and (6) working to assert human rights and land rights. These strategies are closely interrelated in Aboriginal worldviews. For example, subsistence activities related to traditional foods involve cultural knowledge and language, and ceremonial practices with spiritual meaning. Interventions that target one or more of these factors may promote community resilience.

Revitalizing cultural traditions does not mean rejecting modernity. It is more than simply a return to the past. Culture is best understood as an ongoing, creative process of self-definition and self-fashioning, rather than a timeless, static system or backdrop on which life events occur. For example, ecotourism on Aboriginal land represents a new way of relating to the land but may tap into traditional knowledge and values of hospitality toward the stranger. Teaching visitors about living on the land then becomes a way to honor, preserve and promote Aboriginal culture. However, fostering such ecotourism may require innovation in terms of using the internet and communications technology to market and facilitate such ecotourism. This may bring new skills to an Aboriginal community which can be utilized in other business domains. Tradition and modernity may thus intertwine to revitalize a culture and thus enhance community resilience.

Much of the material reviewed suggests that a spiritual outlook on life and participation in ceremonies contribute to individual resilience. Additionally, given that they often are communal events, ceremonial activities can be highly effective in forging a sense of connection to others in the community. Participation in activities such as a powwow or sweatlodge brings both individual and community benefit. Participants in a sweatlodge reported higher levels of self-

discipline, self-actualization, caring for others, and sense of creativity after a ceremony (Schiff & Moore, 2006). Walters and Simoni (2002) observed that spiritual and cultural engagements like the sweatlodge ceremony and Native crafts contributed to positive "identity attitudes" in women, mitigating their negative health concerns. Promoting community resilience may involve supporting the renewal and consolidation of Aboriginal spirituality and ceremony. This occurs internally to communities but can be supported by sharing across communities and by resources to develop heritage centres, and protect sacred sites and other settings needed to conduct ceremonies.

Aboriginal people have always had an intimate and abiding relationship with the land. This has persisted, despite land expropriations and forced sedentarization on non-traditional lands. Several studies suggest that spending time on the land and conducting meaningful activities lead to improved health and well-being. As such, programs that facilitate and support bush activities with family and other community members, especially those that are inter-generational, should foster community resilience.

Indigenous languages contain much cultural knowledge about the environment, human relationships and moral systems and, as such, constitute a previous resource for the community, and for humanity as a whole (Harrison, 2007). There is evidence that language revitalization can play an important role in community resilience (Hallett, Chandler & Lalonde, 2007). Funding and promoting language revitalization efforts may be a key intervention, especially in settings where languages are under threat. This may involve educational programs as well as community or population-level interventions such as the development of radio or websites in Aboriginal languages.

It should be noted, however, that some of the work suggesting the importance of language revitalization comes from places such as British Columbia where there is a large variation of language retention among different First Nations communities. There are many communities, mainly in remote and northern regions that have very high rates of language retention, but also have high rates of suicide and other mental health problems. Language revitalization may thus be most important in communities where local language use is in the minority or in decline. Language alone is not sufficient to protect communities from the effects of social and economic adversity, however as part of a broader approach support for language learning may promote community resilience. Language revitalization may also be an important intervention for urban Aboriginal people. Language classes in cities may bring together otherwise isolated people to participate in culturally meaningful

activities and reinforce a sense of community, belonging, cultural knowledge, and pride. Such classes could also be open to some interested non-Aboriginal people to enhance linking social capital. This would have the added effect of improving understanding and appreciation of Aboriginal culture and worldviews in the broader society, which in turn, can contribute to resilience in Aboriginal communities.

In many Aboriginal communities, cultural knowledge and identity are transmitted through oral tradition. Facilitating the exchange and telling of stories may be an important factor in developing community resilience. Places and events should be set up that encourage story telling in Aboriginal communities. In the clinical setting, Gone (2006) has advised practitioners to assess their clients' "cultural identity status" in the process of formulating therapeutic goals. He suggests that practitioners support distressed clients in reconstituting cultural identity as a form of wellness. Undoing self-pathologizing narratives, for example, may help resolve identity confusion. The same process can occur at the community level. Narrative interventions can also be extended beyond the family, as when communities work to establish, maintain and access collective cultural and spiritual histories.

In the clinical setting, Landau (2007) encourages use of the "genogram," a pictorial display of family relationships and health histories, to map the connections between personal, historical and social events. This can help individuals to understand their predicaments in terms of larger historical forces. The same strategy can be extended to families, groups or whole communities through group discussions and explorations of collective identity.

6.2 Strengthening Local Control and Collective Efficacy

Many studies suggest that collective efficacy and local control are important determinants of well-being in Aboriginal communities. Ledogar and Fleming (2008) argue that collective efficacy is especially pertinent in the Aboriginal context; they cite the definition of Sampson and colleagues collective efficacy as "the capacity of a group to regulate its members according to desired principles – to realize collective, as opposed to forced, goals" (Sampson, Raudenbush & Earls, 1997, p. 918). Collective efficacy reflects the extent to which people feel they can count on their community to take specific forms of action needed to insure their collective well-being. Collective efficacy and local control are important because colonialism, government control and tutelage have undermined traditional political structures and autonomy. New assaults on Aboriginal

communities have come from global enterprises and market forces that operate without concern for local governance. Political activism allows Aboriginal people to defend their communities against these external forces. Local control can insure that services are tailored to the needs of the community (Bowles & Gintis, 2002).

The work of Chandler and Lalonde suggests that local control and collective efficacy in Aboriginal communities are key determinants of community well-being. In their studies, the predictors of health and resilience include: 1) securing legal title to traditional land; 2) establishing self-government; 3) controlling local education, police and fire, and health facilities; 4) preserving and promoting traditional practices; 5) involving women in local governance; and 6) taking control of child and family services. All of these factors can be promoted to enhance community resilience.

Creating and directing local community activities may be essential to collective well-being. To the extent that community members feel a sense of belonging, collective agency, in turn, will support personal agency. Ways of fostering this sense of local control include: community gatherings, community conversations, the collective sharing of feelings, relationships between younger generations and Elders, and language promotion. Community mobilization to address social concerns and collective control over health and other projects are also essential to enhancing identity and self-esteem.

Community empowerment aims to build the capacity within a community to meet challenges. It can do this across multiple domains through interventions that aim to: improve participation; develop local leadership; increase problem assessment capacities; increase critical awareness; build effective organizational structures; improve resource mobilization; strengthen links to other organizations and people; create an equitable relationship with outside agents; and increase local control over programme management (Bopp, 1999; Laverack, 2005). A review of programs in Australia and New Zealand aimed at increasing indigenous community empowerment identified the following factors associated with positive outcomes: community ownership of the problem and solution; the level of existing community empowerment in the local setting; the use of local facilitators; use of outside resource people; establishing trusting partnerships; a local coordinating group; and adequate resources (Campbell et al., 2007).

Kral and Idlout (2008) describe community-generated activities in two Nunavut communities just before each experienced a decrease in suicide activities. One such activity involved the regular gathering of community members over a period of time. Members of the group discussed

recent suicides, and identified their feelings, concerns and motivations about suicide and its prevention in the community. Kral and Idlout call this a space of “synchrony” in which group thoughts generated productive ideas. Similarly, an effective measure in the community of Igloolik involved the establishment of a Youth Committee which met every two weeks to discuss issues and ways to improve community life. Finally, another Igloolik group came together to produce a successful feature film (“Atanarjuat: The Fast Runner”). In light of their experience, Kral and Idlout emphasize that “it does not appear to matter so much what the project is as much as that program or initiative is the community’s own” (Kral & Idlout, 2008, p. 328).

Decentralized and collective power allows communities to determine their own health priorities and establish culturally appropriate programs. In urban centres, Clark (2006) has also found that the best mental health intervention programs depend on community ownership, along with consistent and effective leadership and a culture-focused approach.

Compared to local programs, interventions that are parachuted in from the outside are less likely to be successful in promoting community resilience because they do not build local capacity. Support for the development of local interventions will build local capacity and have broader effects on resilience. This support can include financial resources and expertise that is oriented toward facilitating local program development.

6.3 Supporting Families and Healthy Child Development

Building resilience may involve preventive measures that occur early in development. This can include support for parents and families with young children or early adolescents. Interventions that encourage positive parenting and intergenerational exchange within families are likely to foster community resiliency. This is especially the case given that the residential school system fragmented families and disrupted intergenerational relationships. Programs and services geared to the well-being of Aboriginal communities therefore must facilitate the importance of sharing and cooperation between generations.

Studies have found that Aboriginal youth tend to rely on cultural and social networks for help rather than professional resources. Efforts to target youth problems, such as violence, are therefore moving away from individual psychotherapy toward family and group interventions that incorporate community and cultural values (Clauss-Ehlers & Levi, 2002). Residential treatment programs also have

acknowledged that many protective factors can be best addressed through community and cultural involvement, for example by encouraging traditional Aboriginal teachings that promote morality, humour, creativity, initiative, relationships, independence, and insight (Dell, Dell & Hopkins, 2005). Policies and programs that foster stronger cultural identity by encouraging collective events for sharing Aboriginal history and expressions of cultural pride which are youth-oriented may be helpful interventions.

6.4 Building Social Capital, Networks and Support

Activities that enhance intra-community social cohesion and expand social networks may be very helpful in increasing social support. These include regular collective events such as powwows, educational events with Elders and sports events. Shared spaces where people can gather must be created and maintained; these may include community centers, religious or other community organizational settings, or recreational facilities. Other specific programs and services can be developed to bring people together over common concerns, for example, parenting programs. Given the respect for the wisdom of Elders in Aboriginal communities, such programs can facilitate sharing and cooperation across the generations.

Much research suggests that community resilience may be mediated by natural helping among community members (Waller & Patterson, 2002) and networks. These include organizations such as church support groups, veteran’s organizations, self-help groups, and sporting associations (Sonn & Fischer, 1998; Iwasaki, Bartlett, MacKay, MacTavish, & Ristock, 2005). Such community groups allow sharing of resources (both economic and emotional), and facilitate the propagation of collective systems of meaning that can increase community resiliency. The creation, perpetuation and expansion of such groups may increase social capital and social networks, and be a useful intervention for enhancing community resilience. This type of organization can be developed in both remote communities and in urban settings.

Interventions focused on developing internal links should be complemented by interventions that enhance extra-communal linkages, as this allows for communal empowerment and influence on wider society. Strengthening internal networks and building broader links among communities and across regions will contribute to the communities resilience. Political activities that allow the community to organize around common goals, for example, efforts to regulate regional development, can have a strong effect on the sense of cohesion and collective efficacy.

New media and forms of communication exert a strong influence on individual and community identity. The Internet allows individuals or groups to find others with whom they can form “virtual communities.” For people living in both urban and remote communities, this sense of belonging may buffer the effects of being marginalized in their local communities. Internet forums and websites can help bring people together and be used to efficiently advertise and announce relevant events and activities. As such, the internet can allow people to connect within their own community and also to people outside their community. It may enhance resilience through protective social networks. The internet also provides unique access to knowledge and learning opportunities. As such, increasing access and familiarity with the Internet for both individuals and community groups may close the “information gap” and ensure communities are well-equipped to take advantage of the social and educational opportunities offered by the internet.

6.5 Summary

A wide variety of interventions can enhance community resilience. Table 2 (next page) summarizes some key areas for intervention and examples of effective programs. Although divided by broad categories, most of these interventions overlap. For example, activities on the land involve affirming cultural identity, transmitting cultural knowledge, strengthening social networks and supports, and deepening spirituality. The implication is that there will be broad impact from any of these interventions and powerful synergies when more than one intervention occurs. Measurement of outcomes must therefore also be broad, since some of the positive effects of an intervention may occur in areas that were not its original focus.

While interventions sometimes have impressive short and medium term affects, recent research suggests that some interventions have a delayed impact, which can only be seen in terms of years. These include interventions to enhance parenting skills in order to prevent later suicidal and self-harm episodes among participants’ children. The study by Schiff and Moore (2006) of the effect of the sweatlodge ceremony measures differences in resilience pre- and post-ritual. Though they found a significant impact of ritual, they urge future studies to track effects over a longer period, and over multiple sites. It may also be beneficial to track effects over a sequence of sweatlodge ceremonies to see whether the benefits of resilience accumulate in an additive or synergistic manner. Indeed, it is often challenging to isolate complex, interacting variables over temporal frames. Certain processes of resilience may only apply at specific developmental stages.

7. DISCUSSION AND CONCLUSION

The concept of resilience holds special interest for Aboriginal communities because it focuses on strengths rather than weaknesses or stigmatizing descriptions. Resilience is a way to address the fact that despite historical and ongoing conditions of hardship, many Aboriginal cultures and communities have survived and even flourished. Conditions of adversity and risk have driven both individual and collective responses of healing, recovery and growth. As a result, many Aboriginal communities, families and individuals enjoy high levels of well-being and success in both local and mainstream settings. The resilience framework focuses attention on these positive outcomes, their underlying causes and implications for health promotion.

7.1 Resilience as a Goal

The concept of resilience includes an element of promise tied to larger frameworks of meaning and existence. The various factors that contribute to resilience are both means to achieve well-being and valuable goals in themselves. Sen (1993) has written about this from the perspective of promoting human potential or “capability.” Human capabilities are not just instrumental means to an end, but have a moral claim to be developed for their own sake. Movements for indigenous self-determination aim to create the sustainable conditions of autonomy, empowerment and the realization of capabilities for individuals and communities.

Resilience is important for its role as an “indicator” of mental health that assesses critical levels of health, well-being and productive activity in Aboriginal communities. Indicators make it easier to measure outcomes, allocate public resources and influence policy development (Crossman, 2008). The model of resilience and the corresponding choice of indicators directs attention to specific social processes with implications for policy and practice. As Luthar and Cicchetti (2000) have said: “the resilience framework serves to direct interventionists to empirical knowledge regarding the salience of particular vulnerability and protective processes within the context of specific adversities” (p. 860). In terms of group and community dynamics, resilience highlights the specific types of adversities, and specific types of strengths of various groups and communities.

Community resilience also has important implications for efforts to promote mental health in Aboriginal communities. Interventions to promote community resilience include: strengthening social capital, networks

Table 2. Promoting Community Resilience

Resilience Factor*	Intervention	Examples
Revitalizing language, culture and spirituality	Cultural revitalization Language revitalization Connection with the land	Culture camps Language programs Hunter support programs Sharing of history and tradition through storytelling (Pilgrim et al., 2009)
Local Control and Collective Efficacy Leadership	Community empowerment Programs to develop youth leadership Political activism Indigenous rights	Volunteer Youth in the Millennium, Canadian Rural Partnership website http://www.rural.gc.ca/programs/ Community collaboration on assessment of unmet needs
Healthy Families and Child Development	Early childhood programs Parent education Support for mothers and families Family-centred programs Prevention child maltreatment and domestic violence Programs to create meaningful work, play and relationship opportunities for youth	Triple P-Positive Parenting Program (Sanders et. al. 2002) http://www.triplep.net PROSPER (PROmotion School-community-university Partnerships to Enhance Resilience) (Spoth et al., 2004) Other programs (Connors & Maidman, 2001)
Building social capital, networks and support	Create voluntary associations Community activities Recreational and leisure activities	Community collaboration (Johnson, Grossman & Cassidy, 1996)
Infrastructure and support services	Developing adequate housing, services, and material resources Access to information resources Development mental health services	Developing parks, place spaces, and communal meeting places
Economic opportunity, diversification and innovation	Support for local businesses and small-scale industry Promoting slow growth that fits community values and aspirations	(Wuttunee, 2004)
Diversity of people and perspectives	Community events to celebrate diversity Anti-racism and discrimination programs	Powwows and other activities that bring diverse people together

*Based in part on Hegney et al., 2008.

and support; revitalizing language, culture and spirituality; supporting families and parents to insure healthy child development; enhancing local control and collective efficacy; building infrastructure (material, human and informational); increasing economic opportunity and diversification; and respecting individual and cultural diversity within the community.

Resilience is a broad and flexible concept, encompassing processes of risk and vulnerability, growth and transformation, culture and community, social structure and personality, and power and agency. Resilience brings together a wide array of interacting factors that are best understood in relation to each other. This integrative view is consistent with Aboriginal philosophies that recognize the physical, emotional, intellectual, and spiritual dimensions of experience as essential to a balanced life. The social or communal dimensions of this balance include: knowledge of language, history and tradition; cultural and collective identity; development of traditional skills or know-how; the maintenance of kinship and connection; and spirituality, expressed in part through respect for the environment and the natural world. Most of the models of resilience discussed in this review acknowledge these cultural and spiritual elements. At the same time, thinking about resilience requires that we remain attentive to the specific forms of adversity and suffering that have shaped contemporary life in Aboriginal communities.

7.2 Models and Measures of Community Resilience

The sources of community resilience distinctive to Aboriginal communities include: connections to family and community, which are structured according to indigenous concepts of interdependence and caregiving across the life cycle; oral tradition and storytelling which provide vehicles for the transmission of cultural knowledge and values, as well as adaptive strategies of humour, context-sensitive thinking and creative problem solving; connection to the land and the environment which are central to indigenous notions of personhood; healing traditions which provide paths for personal transformation and interpersonal conflict resolution; ceremony and spirituality which provide access to collective wisdom, awareness of the modest place of human beings in the world, and a sense of the connectedness of all beings; cultural knowledge and identity which connect the individual to a valorized history as First Peoples; cultural continuity which maintains a sense of the meaningful trajectories of each person from past through present to a future with hope and possibility; and collective agency and political activism which give individuals and groups

the tools to challenge the forces of oppression and to work actively to make their own future.

The concept of community resilience has important implications for efforts to promote mental health in Aboriginal communities. However, there are many approaches to community resilience and not all fit equally well with Aboriginal values or realities. A model that works well for some types of Aboriginal community may not capture essential aspects of another Aboriginal context. Aboriginal communities vary widely in size, demography, geographic location, history and culture, with consequences for both their internal dynamics and their interactions with the rest of society and with global systems. Many Aboriginal communities have undergone profound changes as a result of colonization, bureaucratic control and interactions with neighbouring communities and populations. Each model of resilience must be evaluated in terms of its relevance to a particular community's history, current situation and future development.

Social capital is a potentially useful concept for understanding resilience in Aboriginal communities. The literature on social capital offers potential models of the internal and external relationships of communities. It captures social elements such as sharing and reciprocity that are fundamental to Aboriginal perspectives (Mignone & O'Neil, 2005). However, social capital requires systematic rethinking to be applicable across different geographic settings and cultural contexts.

7.3 Holism and Systems Thinking

Resilience depends on complex interactions within systems, including physiological and psychological processes within an individual and social, economic and political interactions between individuals and their environment, or between a community and the surrounding ecosystem and the larger society. As a result, resilience can only be understood by considering systems in their ecological and social context. In the case of communities, resilience is determined both by dynamics and by structural issues influencing access to resources, political organization and collective efficacy.

Some of the structural problems faced by communities result from government policies and administrative practices, notably the segmentation of policies, programs and services that aim to address issues of mental health, substance abuse, social services, corrections, and other social problems that are all aspects of the same underlying social problems. This artificial separation of practices, professions, aggravated by conflicts over jurisdictions (Macdonald, 2008) has imposed wrecked havoc with Aboriginal communities. Government can play a useful role in facilitating community

resilience by creating cross-cutting programs and responses, decentralizing power, and insuring that people working in communities can work together without impediments.

Technocratic control and bureaucratic rationalization tend to look at elements of community in isolation, disconnecting them from their original contexts and emphasizing their place in relation to the bureaucratic system rather than the larger system as a whole. As a result, they break dynamic cycles or feedback loops into linear cause and effect relationships. Evaluations based on this segmented view use isolated measures or indicators of outcome and value (e.g. cost, symptoms, functioning in specific domains, etc.). The result is a lopsided picture in which certain positive outcomes are targeted without noticing that others lag behind or even worsened by the same intervention. Interventions that target single aspects of the community do not take advantage of the natural synergies or reinforcement that occurs with multi-system interventions.

Health and well-being cannot be divorced from other areas of community life. Alternatives to the conceptual “silos” of government, include the holistic or integrative models of systems theory. The metaphoric map of the medicine wheel provides a tool for thinking about and moving toward holism. The medicine wheel describes the goals of balance in broad strokes. The advantage of framing the issue in such general terms is that it allows us to survey situations broadly and to shift attention from one component to another as the situation evolves. However, the balance depicted in the medicine wheel must be elaborated in specific contexts to assess relevant dimensions and devise appropriate remedies. This can be done by borrowing models from developmental systems theory in biology and psychology, family systems theory, ecosystems theory, and community development.

7.4 The Future of Community

The resilience of Aboriginal communities also depends in part on their relationship with the larger society and with government institutions. Addressing the divisive policies and practices in government at all levels and enhancing public knowledge of and respect for Aboriginal cultures, traditions and aspirations is a necessary part of any comprehensive effort to promote community resilience.

The emphasis on community resilience reflects Aboriginal values of respect for the family, interdependence, connectedness, and coexistence. However, we should not over-simplify and romanticize the notion of community. Communities provide support and nurturance for human beings and an essential sense of belonging but they also exact costs in terms of constraints on freedom and pressures to conform (Bauman, 2001). There are many types of

communities, with different sizes, histories and dynamics. They have different types of problems. Some communities were newly created as a consequence of all the forces of colonization and subsequent government influence. Some have a lot of resources and simply need government agencies to be enablers (and then “get out of the way”); other communities are fragile, vulnerable and need significant outside support to jump start the internal process of building capabilities and resilience.

Even where communities are well-resourced and well-functioning, there is diversity among individuals in needs, opportunities and aspirations. This diversity means that there will be some individuals who need contact with outside helpers to solve their individual or family problems, whether they need the privacy, support and “neutrality,” or the new perspectives offered by someone from outside the community. Similarly, not everyone within a given community subscribes to the same tradition, form of spirituality or sources of meaning in life. The modern world is diverse and most communities mirror this diversity to some degree. In addition to building solidarity, communities must create pluralistic systems that allow individuals or groups to find their own paths.

At a still higher level, even as they struggle to maintain and deepen their roots to a specific place and tradition, Aboriginal peoples must participate in the larger political, moral and ecological project of making our planet a sustainable home for humanity. Aboriginal knowledge, values and perspectives have a crucial role to play in developing the resilience of the human community. This contribution, in turn, will strengthen the resilience of Aboriginal communities themselves.

APPENDIX A. GLOSSARY

Bonding social capital is defined as linkages that are focused within the group and characterized by homogeneity, strong social norms, loyalty, and intra-group ties that tend to exclude others outside the group.

Bridging social capital is defined as outwardly focused linkages, that include diverse groups and people. This would include links between a community and the surrounding communities or the larger “mainstream” society.

Category Fallacy: the erroneous and uncritical imposition of a category developed in one culture onto another very different culture.

Community: a group of people who live together or are connected through emotional bonds with each other and the group, shared connection to place, common interests, values, and activities and identities.

Community-level: factors that are properties of communities, for example, pollution, collective efficacy and generic trust.

Cross-sectional research: a study design where exposure and outcome variables are collected simultaneously.

Ecological Capital: a broader concept than social capital that encompasses four domains: natural capital (the surrounding biological ecosystem and environmental resources); human capital (skills, health, abilities, education, and the cultural values of community members); social capital (bonds between individuals as well as across wider voluntary or institutional networks and organization; and built capital (roads, homes, equipment, and other human-made structures).

Epidemiology: the scientific study of the distribution and determinants of health and illness in populations.

First Nation(s): an Aboriginal community that is recognized by Indian and Northern Affairs Canada (INAC) that typically has federal reserve land and registered membership defined by the Indian Act as status Indians. A First Nation community may also include other land and members.

Generalizability: the extent to which findings from a specific study sample can be generalized to either: (i) the local population (sometimes known as internal validity); or (ii) the population at large (sometimes known as external validity).

Incidence: the number of new cases of a health problem occurring in a population over a specific period of time (e.g. one month, 12 months).

Individual-level factors: factors that are properties of individuals, for example, age, gender and income.

Linking social capital: the degree of integration and social efficacy of groups within a hierarchical society

(including, for example, the relationship with various levels of government).

Longitudinal research: a study design where a cohort of people are followed-up over a specific period of time with exposure variables measured at baseline and outcome variables measured after a period of elapsed time.

Prevalence: the number of cases with a health problem in a population (usually expressed as a percentage of the total population; also sometimes specific in terms of a time period).

Protective factor: a factor that reduces the likelihood of developing a health problem.

Qualitative research: a research methodology which involves the collection of non-numerical data, mostly in the form of in-depth interviews, focus groups and participant observation.

Risk factor: a factor known to increase the possibility that an individual will develop a health problem.

Social capital is an umbrella term used to describe aspects of social networks, relations, trust and power, either as a function of the individual, or as a function of a geographical region (e.g. a First Nation community).

Social networks refer to the extent and nature of linkages between individuals.

Social support refers to individual-level instrumental and emotional support received by one individual from other individuals.

Structural violence refers to forms of violence that occur because of the way societies are structured to create and maintain inequalities, harmful and oppressive circumstances that cause illness and injury to people.

Vertical social capital: (see Linking social capital).

APPENDIX B. QUESTIONS FOR DISCUSSION

What are the dimensions of resilience at the level of the community? How do these differ from individual resilience factors?

What aspects of resilience identified in other communities apply to Aboriginal communities?

What are the unique or distinctive facets of resilience in Aboriginal communities?

What are the advantages and disadvantages of using social capital as a framework for understanding and measuring community resilience in Aboriginal communities?

Is social capital mainly a Eurocentric concept, or does it resonate with Aboriginal values and worldviews?

What does the concept of social capital omit that may be important in community resilience for Aboriginals?

Do different sizes, locations and organizations of communities require different models and measures of resilience?

What are the key dimensions of Aboriginal community resilience?

In practical terms, which factors are easiest to recognize, monitor or measure over time and across communities?

Which existing measures should be tailored to the Aboriginal perspectives? What form should this process of tailoring take?

What are the most feasible and effective methods to promote Aboriginal community resilience?

APPENDIX C. RESOURCES ON COMMUNITY RESILIENCE

Community Capacity Building – A Practical Guide
Prepared by Dr Rowland Atkinson and Paul Willis of the Housing and Community Research Unit, School of Sociology, University of Tasmania (2006) <http://www.utas.edu.au/sociology/HACRU/6%20Community%20Capacity%20building.pdf>

Building Resilience in Rural Communities Toolkit

The University of Queensland and University of Southern Queensland:

http://learningforsustainability.net/pubs/Building_Resilience_in_Rural_Communities_Toolkit.pdf

The National Disaster Recovery Principles

South Australian Government (2008)

<http://www.dfc.sa.gov.au/pub/default.aspx?tabid=196>

Community Builders NSW

an interactive electronic clearing house

<http://www.communitybuilders.nsw.gov.au/>

Assessing a community's capacity to manage change: A resilience approach to social assessment

Brigit Maguire and Sophie Cartwright, Bureau of Rural Sciences, May 2008

http://www.affashop.gov.au/PdfFiles/dewha_resilience_sa_report_final_4.pdf

The Community Resilience Manual: A resource for rural recovery & renewal

Canadian Centre for Community Renewal

<http://www.cedworks.com/communityresilience01.html>

Mental Health Foundation of Australia, Resiliency Resource

http://www.embracethefuture.org.au/resiliency/resiliency_model.htm

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5. <http://www.preventioninstitute.org/thrive.html>

6. The term 'structural violence' was coined by Galtung (1986) and has been used by many to analyze social origins of health inequalities (Desjarlais et al., 1995; Farmer, 2003).

END NOTES

1. "Protection" and "resilience" are sometimes used interchangeably. LaFromboise et al. (2006) for instance discuss resilience as a "protective mechanism that modifies an individual's response to risk situations and operates at critical points during one's life" (194). Protective factors identified through these studies may point to mechanisms of resilience.

2. http://www.fahcsia.gov.au/sa/communities/progserv/Pages/business_continuity_pandemic_planning.aspx, Accessed August 8, 2009

3. Social networks are one way to define communities. According to Piselli (2007), a community is "not a 'place' but a network of meaningful social relations with friends, neighbours, relatives, and work colleagues" (p. 867).

4. For Bourdieu, "Social capital is the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition—or in other words, to membership in a group—which provides each of its members with the backing of the collectively-owned capital, a 'credential' which entitles them to credit, in various senses of the word" (1996, pp. 248-249)